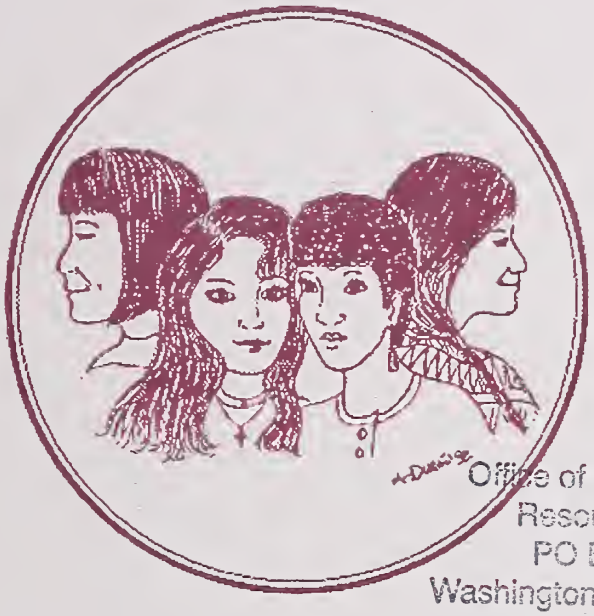
Women of Color Working Together



Office of Minority Health
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PO Box 37337
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Final Report

November 2-4, 1994

Sponsored by

U.S. Public Health Service, Region VIII

Office of Population Affairs

Office on Women's Health

Office of Minority Health

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Women of Color Working Together

Final Report

Compiled and edited by

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U.S. Public Health Service, Region VIII

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This document is a report of the conference, "Women of Color Working Together." It is a compilation of the statements of conference participants, and the opinions expressed herein do not necessarily represent the official views of the sponsoring agencies.

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A special thank you is extended to Nancy Dworak, Region VIII Public Health Service secretary for Minority Health, who spent many hours transcribing the presentations of our speakers, and who provided much assistance during the conference planning and implementation stages. Her invaluable assistance was most appreciated.

Thank you again to Aileen Duran, Secretary to the Region VIII administrator of the Administration for Children and Families whose art work appears on the cover of this report.

Table of Contents

Introduction i - xii

Opening Ceremonies
- Margaret Cary, M.D., M.B.A., M.P.H. 1
- Evelyn Glass 2
- Suzanne G. Haynes, Ph.D. 3
- Hugh S. Sloan, D.S.W. 7

Featured Presentation
- Mary Chung 8

Special Session
- Cecelia Fire Thunder and Theda New Breast-Ramos 13

Keynote Presentation
- Maria Guajardo, Ph.D. 29

Panel Presentations
- Ruth L. Fuller, M.D., F.A.P.A. 37
- Geri Reyna-Challis 41
- Abby Trujillo Maestas 44
- Sylvia Guillermino Corral, M.D., M.P.H. 47
- Estella C. Parrott, M.D., M.P.H. 50

Special Presentation
- Agnes Donahue, D.D.S., M.Sc.D., M.P.H. 55

Conference Workshops Summary 63

Appendix 67
- Ethnic Women of Excellence in Health Awards 68
- Facilitators Networking Tables 69
- Ethnic Events 70
- Region VIII State Meeting 71
- List of Participants by State 74

Women of Color Working Together: A Regional Public Health Conference

In June of 1992, the U.S. Public Health Service, Region VIII sponsored the first-ever conference to address the needs of women of color, "Minority Women: Dimensions in Health." The conference attendees, meeting in a series of focus groups and health tracks, analyzed the impact of the woman's life cycle, interagency linkages and systems challenges, and racial or ethnic influences on the health of minority women. Five general health subject areas were identified: mental health, substance abuse, violence, reproductive health and chronic disease. Recommendations were formulated for many of the issues identified, and states presented their plans for action.

The report of the proceedings from the 1992 conference has received wide interest and distribution, and the disparities in health status to be found in women of color have begun to be recognized. State activities have included

- the establishment of the Utah Ethnic Women's Health Coalition, which sponsored a minority women's conference in November of 1993;
- a minority women's conference sponsored by the Wyoming Department of Health in September of 1993;
- an Indian women's conference held in Montana in September 1993;
- the establishment of the Colorado Minority Health Coalition in Colorado in December of 1992;
- an ongoing series of radio broadcasts on the health issues of Indian women in South Dakota;
- plans by Indian women in North Dakota to sponsor a conference in 1995; and
- plans by Latinas in Colorado to sponsor a conference on substance abuse in Latinas in 1995.

Dr. Agnes Donahue, at that time the director of the Office on Women's Health, was the primary impetus for the 1992 conference. In 1994, the Office on Women's Health, with generous support from the Office of Population Affairs, has provided the means for a second Region VIII conference on the health issues of women of color. The goals for this conference are

- to begin the process of healing within women of color and their communities in order to move forward;
- to learn how to overcome the barriers which prevent healthy change from occurring.

Activities at the federal level include the establishment of the PHS Coordinating Committee on Women's Health and the Office on Women's Health, the Congressional Caucus on Women's Health, the PHS Action Plan for Women's Health , and the inclusion of objectives for women and minorities in the Healthy People 2000 plan. These activities have provided the framework and incentives for regions, states and communities to begin to address the disparities in health status and the health service gaps which are issues for women of color. Region VIII staff — Hugh S. Sloan, Acting Regional Health Administrator; Charlotte Gish, Reproductive Health Consultant; Nancy Thomann, Minority and Women's Health Coordinator; and Jane Wilson, Regional Program Consultant — are pleased to have a role in forwarding this agenda in Region VIII.

Planning Committee Acknowledgments

A very special thank you is extended to the following women who served on the Planning Committee for the Women of Color Conference. The input from these individuals provided the framework, the focus and the essence of this conference, and the success of the conference was due primarily to their commitment to improving the health and well-being of women of color.

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The following individuals and organizations have supported the conference by providing financial resources, staff time and effort, or information or data, and the U.S. Public Health Service in Region VIII wishes to convey its special thanks to each of them.

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Conference Agenda

Women of Color Working Together

Sponsored by U.S. Public Health Service

Wednesday, November 2, 1994

9:00 A.M. – 1:00 P.M.	**Registration**
1:00 – 2:00 P.M.	**State Introductory Gatherings**
2:00 – 3:30 P.M.	**Plenary Session:** ***Opening Ceremonies & Welcoming Remarks*** Margaret Cary, M.D., M.P.H., M.B.A. Regional Director, Department of Health and Human Services Gerald Bennett Acting Deputy Assistant Secretary, Office of Population Affairs Suzanne G. Haynes, Ph.D. Senior Advisor, Office on Women's Health Audrey F. Manley, M.D., M.P.H. Acting Deputy Assistant Secretary, Office of Minority Health Hugh S. Sloan, D.S.W. Acting Regional Health Administrator **Featured Presentation:** **"Women of Color: Looking Forward to a Healthy Year 2000"** Mary K. Chung Founder and Executive Director National Asian Women's Health Organization Oakland, California
3:30 – 4:00 P.M.	Break
4:00 – 6:00 P.M.	**Special Session:** **"Healing Our Inner Selves"** Cecelia Fire Thunder (Oglala Sioux) Training Specialist, South Dakota Department of Health and Medical Services Martin, South Dakota Theda New Breast-Ramos, M.P.H. (Blackfeet) Training Coordinator, The Circle, Inc. Montana

Thursday, November 3, 1994

8:30 – 9:30 A.M.

Plenary Session:
Keynote Presentation
Maria Guajardo, Ph.D.
Executive Director, Latin American Research and Service Agency (LARASA)
Denver, Colorado

9:30 – 10:00 A.M.

Break

10:00 – 11:30 A.M.

Panel Presentations:
"Update: The Dimensions of Women's Health"

Mental Health
Ruth L. Fuller, M.D., F.A.P.A.
Associate Professor, Psychiatry
University of Colorado Health Sciences Center
Denver, Colorado

Substance Abuse
Geri Reyna-Challis (Taos Pueblo)
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Violence
Abby Trujillo Maestas
Executive Director, Salt Lake Rape Crisis Center
Salt Lake City, Utah

Chronic Disease
Silvia Corral, M.D., M.P.H.
Clinic Medical Director, Salt Lake Community Health Centers
Salt Lake City, Utah

Reproductive Health
Estella Parrott, M.D., M.P.H.
Center for Devices and Radiological Health
U.S. Food and Drug Administration
Rockville, Maryland

11:30 A.M. – 1:00 P.M.

Luncheon — Mexican Buffet
"¿Que Pasa?" (Spanish for "What Is Happening?")

Presiding
Selina Jaramillo and Betty Roybal

Storytelling
Geraldina Lawson, R.N.
Administrator, Globeville Community Health Clinic

Networking Tables on Various Health Topics:
Cancer, Diabetes, AIDS, Mental Health, Substance Abuse, Teen Pregnancy, Domestic Violence, Menopause, Sexually Transmitted Diseases, Language Barriers, Physical Activity, Nutrition, Contraceptives, Tobacco, Aging Issues, Stress Reduction, Family Planning

1:00 – 2:00 P.M.

Workshops, Session I:

Track I — Prescription for a Healthy Community
A. Community Wellness Strategies

Track II — Caring for the Caregivers
B. The New You Moves Forward!

Track III — Overcoming Barriers to Change
C. Recruiting and Retaining Providers of Color

2:00 – 3:00 P.M.

Workshops, Session II:

Track I — Prescription for a Healthy Community
D. Community Advocacy for Women of Color

Track II — Caring for the Caregivers
E. Making Positive Choices

Track III — Overcoming Barriers to Change
F. Adding Warmth and Compassion to our Health Care Services

3:00 – 4:00 P.M.

"Balancing the Yin and Yang in Your Life"
Asian/Pacific Island Break

Presiding
Jae Wha Ahn

Activities
Tomiko Takeda, M.Ed.
Wellness Consultant

Toni Iadresin, D.C.
Chiropractor and Tai Chi Instructor

4:00 – 5:30 P.M.

State Meetings, Session I

Friday, November 4, 1994

7:30 – 9:30 A.M.	**Awards Breakfast**
	"Indian Honoring Ceremony" for Ethnic Women in Health
	Presiding Cecelia Fire Thunder and Jane Wilson
9:30 – 10:30 A.M.	**Workshops, Session III** *Track I — Prescription for a Healthy Community* G. Healthy Communities = Healthy Families *Track II — Caring for the Caregivers* H. Asserting Yourself Positively *Track III — Overcoming Barriers to Change* I. Blending Alternative Therapies and Spirituality with Western Medicine
10:30 – 11:00 A.M.	Break
11:00 A.M. – 12:00 Noon	**State Meetings, Session II**
12:00 Noon – 2:00 P.M.	**Lunch & Closing Ceremony** **Special Presentation** **"Women of Color and Health Care Reform"** Agnes Donahue, D.D.S., M.Sc.D., M.P.H. Office of Intergovernmental Affairs U.S. Public Health Service *Closing* **"Umoja (Unity) Ceremony"** (African American) *Presiding* Kathy Rollins and Nancy Thomann

Opening Ceremonies

Opening Ceremonies

MARGARET CARY, M.D., M.B.A., M.P.H.
Regional Director
U.S. Department of Health and Human Services, Region VIII

Just a few short months ago I was practicing women's health care and doing a television show. My how things change! First of all, welcome to all of you here. Welcome, on behalf of Secretary Shalala, to this conference. I would like to give a special thanks to those who planned this conference. I feel that there has never been an administration that has been as committed to improving women's health as the Clinton Administration. And many goals of this Administration particularly assist women of color.

Even though health care reform wasn't passed in the last session of Congress, President Clinton remains determined to seek health care that can never be taken away. Women - and particularly women of color because of poverty - are often forced to choose between working and having no health insurance coverage, or turning to welfare for Medicaid. They should not have to choose between health care for themselves or health care for their children. The system should provide for all.

If you saw my television program "The Health Care Puzzle" we had a woman named Laura (a true story) who had been homeless. She went to Emily Griffith Opportunity School, became a practical nurse, and had started working in a nursing home. But she couldn't afford health insurance. Her children were able to get it through Adams County for a nominal fee. But she hadn't had a Pap test, or a mammogram, or any of those things, because she couldn't afford insurance for herself. It seems it's a perverse incentive, and that's what we were trying to point out.

President Clinton also is determined to reduce the plague of violence. Six thousand people a day suffer physical injury as a result of interpersonal violence. I used to direct an emergency room, and I can tell you, violence does happen. In fact, emergency room doctors have formed groups to deal with violence. We are considering it a plague. Twenty to 30 percent of women in the emergency room are there because of physical violence. We have to build strong families and strong communities in order to address this issue.

We also have a problem with immunizing our children. Thirty percent of children under two are not properly immunized. What this Administration is trying to do is to make more vaccine available to those who need it. Healthy kids really deserve a valuable resource.

I'm here to show my commitment, and that of our President, to help find solutions for women of color, and I look forward to hearing your recommendations. I will do what I can to assist in bringing those to the attention of the officials in Washington. I'd also like to say that this Administration is particularly determined to work with Native Americans. A new position has been created - lead Regional Director for Native American issues - and I have been appointed to that position. With that, I'd like to encourage all of you to see "Black Elk Speaks," which is playing here in Denver.

EVELYN GLASS
Regional Operations Officer
Office of Population Affairs, Office of Family Planning, U. S. Public Health Service

To Dr. Cary, to Dr. Sloan, and to participants in Region VIII's second public health conference addressing the health issues of women of color, I bring greetings from Dr. Felicia Steward, Deputy Assistant Secretary for Population Affairs, and Jerry Bennett, Deputy Director of the Office of Population Affairs. Both regret that they could not be here today, but it is my pleasure to be here with you and to represent our office.

OPA has had the opportunity to co-sponsor a number of regional women's health conferences across the nation. OPA's central and regional staff have worked closely with the Office on Women's Health in planning the conferences. Having OPA's input and support makes sense. As you can see, of the nearly 4.5 million persons served annually by the federal Title X Family Planning Program, over 95 percent are women. In fiscal year 1995, the Title X program will support a network of more than 4,200 clinic locations across the country, with a total funding of $190 million. Family planning clinics make up the largest group of accessible clinics where women can be served on a sliding fee basis for preventive health services. Here in Region VIII, serving six states (Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming), nearly 200,000 women receive, in addition to contraceptive counseling and services, breast and cervical cancer screening, cancer diagnosis and treatment, STD tests, HIV/AIDS counseling and substance abuse counseling.

Family planning clinics have always been very concerned about the clients with the highest risk and those who have limited access to services. For many of the new clients, it is their first entry into the health care system. Given this, it is natural that OPA is not only involved, but a leader in promoting the women's health initiative in the department. We will continue to propose policies and initiatives in the federal family planning program that will improve and protect the health of women of color. We plan to continue to provide core public health and family planning services to underserved populations, and to increase outreach to persons unlikely to seek services - persons such as homeless people, substance abusers and adolescents. We will emphasize comprehensive, integrated and culturally appropriate reproductive health services, and support information dissemination on reproductive health issues. We are eliminating disincentives to serving high-cost clients, to using high-cost contraceptives, and to providing community education. This means that Title X funding will no longer be based solely on the number of persons served, but rather on how well a project reaches the hardest to reach.

We are placing major emphasis on recruiting and retaining nurse practitioners in family planning clinics. Each regional nurse practitioner training center has received funds to provide scholarships for minority nurses who need a subsidy to attend advanced nurse training. We will continue to support relevant research to increase the body of knowledge on how to improve reproductive health service delivery, as well as research on contraceptive development. We will continue to work and to co-sponsor initiatives with other agencies of the Public Health Service, such as the Center for Disease Control and Prevention, Substance Abuse and Mental Health Administration, the Food and Drug Administration, the Indian Health Service, and the Office of Minority Health, in order to advance women's health issues. I am very glad to be here with you, and I look forward to hearing the scheduled speakers, and to dialogue and exchange with each one of you.

SUZANNE G. HAYNES, PH.D.
Assistant Director for Science
Office on Women's Health, U.S. Public Health Service

I want to recognize Agnes Donahue for her wonderful work in supporting these regional health conferences, and I bring greetings from Dr. Susan Blumenthal, Deputy Assistant Secretary for Women's Health. We want to continue supporting conferences like this in your region, and would like to know from you what the next topic should be, and how we can participate with you.

We also want to know from you how we can help the efforts in your region. In fact, during my talk I'm going to go through some of the priorities and concerns that we have in the Office on Women's Health, but I'd like you to write down on a piece of paper what you think we could do for you and how we can work together. Could we help sponsor a newsletter? Could we help sponsor conferences or teleconferences? Is there some special project that you are planning that we might help support? At least tell me what you think the major health issues in this region are, and which are the top priorities.

Why has the Office on Women's Health been elevated to a deputy assistant secretary's position? Why the increased interest? You may have noticed over the last four years that the press has been drawing attention to the fact that there has been very little research on women and that women have been underrepresented in clinical trials. There has been a lack of information published on the health issues of women of ethnic minority groups and little notice of their obvious inequitable access to health care services. So what are the priority health issues for women as we identify them in Washington?

We've identified four major health areas during *young adulthood or adolescence*: teen pregnancy; HIV/AIDS and sexually transmitted diseases; violence; and psychosocial morbidities. These are probably the top priorities that our office should be focusing on for this age group.

In *middle adulthood*, which is the period from ages 18 to 60, the top cause of morbidity and mortality is cancer. There are also menopause issues. This is the most frequent question our office receives: "Should I take postmenopausal hormones or not?" As with younger women, psychosocial morbidities appear again. Depression and substance abuse also seem to be big problems.

For the *older woman* - age 60 and over - heart disease and stroke are the major killers. Cancer comes in second, and diabetes seems to be a pressing concern of older women, along with musculoskeletal disorders, depression and prescription drug use.

When I started looking at the teenage data, I plotted the chlamydia rates in the United States. If you look at the western states, the highest chlamydia rates in the country appear in this region. It seems the western states are experiencing an epidemic.

The other thing that we've noticed is that the cervical cancer mortality rates among Black women are actually increasing. The incidence rates are also going up. If you've noticed, of all the cancers that we have studied over the past twenty years, cervical cancer rates should not be increasing. There is a suspicion that again, this is due to the sexually transmitted virus, HPV.

The Centers for Disease Control (CDC) has come up with a model that ties all HIV, adverse pregnancy outcomes, cervical cancers, and lower fertility (because of chlamydia exposure) to sexually transmitted diseases. CDC's model shows that if you can get women into your family planning clinics and get them tested for not only cervical cancer, but also for chlamydia and other diseases, you can control a whole spectrum of diseases. The cause of the epidemic is not known, nor has it really been thought about as it should be.

The other thing that we're interested in, particularly this year, is violence against women. The Health and Human Services Secretary, Donna Shalala, has created a task force chaired by Peter Edelman to address the incidence of violence in America. For women it's particularly crucial, because the second leading cause of death among women 15 to 24 years of age is homicide. The leading cause of death among African-American women, 15 to 24 years, is homicide. Sixty percent of homicides among women result from someone they know, and the leading place of death for women is in the work place. Did you know it's not safe to go to work? I didn't know that. In regard to sexual assault, 1,871 women are forcibly raped every day in the United States, and an estimated 22 percent of American women have been sexually assaulted. I think these are astonishing figures. More than 1.5 million American women seek medical treatment for injuries resulting from domestic violence, and those of you who work in emergency rooms actually see these cases. If you look at the homicide rates, there is more violence reported in the West and the South. Our office is going to take the lead in domestic violence prevention. This is what we're dealing with, and it's going to be quite a challenge to be able to curb these trends.

The next group of women that we focused on are middle-aged women - women over 18 and up to age 60. What really strikes us is what's going on with breast cancer and with lung cancer. The lung cancer rates have been rising since 1950, and Black and White women are almost parallel - the same rates, and both are rising. If you look at breast cancer, you can see that the rates for Black women are increasing. In other words, the incidence in 1990 is higher among Black women than among White women, which was not the case in 1980.

Now what's going on? Obviously, for lung cancer we are talking about cigarette smoking. One of the groups that has reported the highest percentages of cigarette smokers in the United States is the American Indian population. I don't know how many people know this, but it's really striking to see the difference. This group is followed by African-Americans, then Whites, and then Asian-Americans with the lowest smoking rates.

This is a problem that we can prevent - it's not exciting, it's not new. We do know something about preventing smoking in men. I don't know that we know as much about cessation in women. You look at lung cancer rates -- those lung cancer incidence rates translate directly into death rates. Black women in this country have the highest death rates from lung cancer of any group next to Whites, and you can see how it goes down. If you look at breast cancer rates, again Black women have the highest breast cancer death rates of any group. And then it's quite interesting to see how Hispanic women's rates are really moving into third place in this ranking. I'm worried that these rates are going to increase over the next few years.

One of the causes of breast cancer is thought to be a high fat diet, or being overweight. If you look at the percentage of women - Black women, Hispanic women, women living in poverty - all these groups have higher-than-average percentages of overweight women. In this country, we have no idea how to help women lose weight. So what are the top four leading causes of death of Hispanics, Blacks and Asian Americans? For Hispanics, heart disease and cancer are the major killers, followed by injuries and stroke. For Asian/Pacific Islanders, the top four are the same: heart disease, cancer, stroke, injuries. And for American Indians, again the same thing: heart disease, cancer, stroke, and injuries are the top four causes of death. For all the populations that you are reaching in your region, these are the risk factors and the diseases that we have to combat.

So how are we in the Office on Women's Health going to address these diseases? How can we help you? First of all, we want to support comprehensive community-based health promotion programs and disease prevention programs for women in any way we can. If you have ideas on how we can support what you are doing in the area of disease prevention, it would be very instruc-

tive for us to hear from you. We want to promote access for all women to a full range of health care services. We want to strengthen research on diseases in women. And we want to educate and inform women about health issues and support health professional training. In other words, let's train the doctors and other health professionals to identify these diseases in women.

Finally, the biggest project that we have under way this year is the National Action Plan on Breast Cancer, which is coordinated by Dr. Blumenthal with Fran Visco of the National Breast Cancer Coalition. This is one of Secretary Shalala's top priorities - to see if we can stop the epidemic of breast cancer. What we want to do is create a comprehensive plan to end the epidemic.

This year, we are putting resources and activities in six areas. One is getting information out to women on prevention and treatment on the information superhighway. Second, we want to get consumer input at all levels of policy making. Third, we want to find out what causes breast cancer. Today, only about 50 percent of the women who develop breast cancer have a known cause. For the other 50 percent, we do not know why this particular disease developed. There is a lot of concern, and it concerns more of you in the West, that the environment - pesticides, radiation, or other types of exposures - may explain the other 50 percent of cases with unknown etiology.

Fourth, we want you to tell us what your patients tell you we should do to help women get adequate treatment for breast cancer, especially access to clinical trials. Women of color are the least likely to enroll in a clinical trial. What is a clinical trial? These are experiments that many universities have going on that test most state-of-the-art drug treatments for breast cancer. For some reason, minority groups are not being recommended and not getting into these trials. They are not getting the state-of-the-art treatment, and the National Action Plan on Breast Cancer is going to address this issue. We are very concerned about underserved and at-risk populations who are generally not studied, never included in trials and never researched. Our goal is to encourage research in these populations.

As a fifth priority, we are concerned with the women who have the breast cancer gene (BRCA1) that you may have heard about in the last couple of weeks. What is going to happen to those women if they go to their insurance companies, and their insurance companies say they have a pre-existing condition and will not give them health insurance? What will happen when they go into the work place and their employers decide to fire them because they happen to have learned that they have the gene? We want to provide some protection for women who might be walking around with a positive genetic profile for breast cancer so that they are not discriminated against on the job or in health insurance.

Our sixth priority deals with the availability of breast tissue in national tissue banks for wider use by scientists who have discovered new screening or biomarker tests and need tissue quickly.

Finally, our office wants to find a new way of imaging the breast - that is, a substitute for mammography, or a better type of mammography for younger women. You may have heard this year that the National Cancer Institute pulled back its mammography guidelines for screening women aged 40 to 49. I looked at the data in several different studies, and the answer was that there is no survival benefit in women ages 40 to 49 for having mammography. Our office just held a conference in Washington where we brought in people from the defense and space industries. These people can look at planets or stars and find little spots millions of miles away. We asked why they could not focus that technology on the breast and find a little lump in the same manner. The point is, we put together for the first time, the mammographers with the Defense Department and the space contractors, and they are starting to talk. The defense industry says that they can do this - that they have had this

technology for ten years. What we are trying to do is stimulate research so that we will have a better imaging machine within the next 10 years.

I again thank you for having us here. And again, Dr. Blumenthal sends her best wishes and hopes to support this conference and more like it in the future.

HUGH S. SLOAN, D.S.W.
Regional Health Administrator
U.S. Public Health Service, Region VIII

I'm pleased to be here today, and to welcome you to Denver. I'm pleased to see that the Office on Women's Health is, in fact, going to be a vocal and very definite spokesperson for women's health. We welcome that new voice with the Deputy Assistant Secretary for Health, Dr. Blumenthal. I also want to extend our thanks to Dr. Agnes Donahue, who has been a loyal supporter of regions and of women and minority health.

I welcome your input and your participation in this conference. I think, as my colleagues have said, there is no doubt that they would like to hear from you, and that is the beauty of this particular conference. This is not a "talking to you" conference. This is your conference to participate in.

If we don't say it, it's going to get done without our voice, and it's not going to get done enough. I hope all of you will participate and come out of this conference with some recommendations that I will be glad to forward. I know Dr. Cary and each of these colleagues who work for various offices in the Public Health Service will be happy to carry your message.

We are looking at restructuring the personal health care system. I think we need to consider that here today. We need to strengthen and redefine the public health system, whether it be environmental health or the regulatory side of enforcement of health standards, the strengthening, redefining and enhancing of the infrastructure that supports both sectors - the medical and the health care systems. We need to start to look at cultures and interest groups, and to recognize that each has a very important role to play, not only in this debate, but in shaping the future.

The Public Health Service basically has six major roles that we are going to try to play as we move down the health care reform path. One, of course, is policy development, and again, I can't emphasize enough - policies can be influenced by people like you and me. The second one is research, as Dr. Haynes mentioned. We need more research, particularly focusing on women, and particularly focusing on minorities. Public health practice - we know we need to do more in that general arena. Education and training. Minorities and women are under-represented in all aspects of our health care provider field. We know we're not doing enough. Women are not being encouraged enough in science and health, and we have to change the system in that regard.

The fifth area is information and data management. We know we've got a lot of information being gathered at a lot of various levels, but it is not being brought together in a way that's always the most helpful. We've got to get that channeled.

For certain populations, the delivery of personal health care services is a responsibility of the Public Health Service. The family planning services that we've heard about, the community health centers that we sponsor, the homeless programs - all of these are what we call a safety net for people who don't have anywhere else to go. Had health care reform passed, we might not have needed some of these safety-net programs, but we are going to need them for the immediate future. I hope that we can establish among this group some goals that are laid out very well in the program.

I think that this is one of the best organized conferences that we have had the privilege to sponsor. The reason it's the best organized is that it has a committee made up of people who are stakeholders. This isn't a federal conference. This is your conference, and I hope that we can achieve the goals that are stated, and that we can start a healing process to get us where we need to go.

Featured Presentation

"Women of Color: Looking Forward to a Healthy Year 2000"

Mary Chung
National Asian Women's Health Organization

Thank you for this opportunity to speak with you today on these critical issues. In addition to representing the National Asian Women's Health Organization, I'm speaking on behalf of two collectives: the Women of Color Coalition for Reproductive Health Rights and the U. S. Women of Color Delegation to the International Conference on Population and Development.

The National Asian Women's Health Organization is a nonprofit, community-based health advocacy organization, committed to improving the overall health status of Asian women and girls. We were founded with the recognition that the needs and concerns of women of Asian descent are at the same time specific and diverse, and that they must be addressed within community, cultural and linguistic contexts. We are committed to redefining privacy and personal freedom within the historical contexts of immigration laws, concentration camps, lack of property rights, and social decisions made by others which shape the Asian-American experience in the United States.

The Women of Color Coalition for Reproductive Health Rights was founded in the spring of 1992. It is comprised of Native, African-, Latin and Asian-American women, and addresses reproductive health issues and concerns specific to women of color. The mission of the Women of Color Coalition is to design and implement a common agenda that influences policy, research, and education for reproductive health rights issues, as broadly defined *by* women of color, *for* women of color, from *our* perspective and on *our* terms. Although the mainstream women's health movement has historically been perceived as lacking leadership and influence by women of color, the fact is, women of color have been integral to the leadership of the reproductive rights and the women's health movement in the United States. Women of color are present in mainstream women's groups in meaningful numbers and positions of responsibility. At many mainstream institutions, women of color have been the driving force behind implementation of policies like affirmative action, pushing for diversity and more representation. Women of color have urged the women's reproductive rights and pro-choice organizations to expand and adopt a larger women's health and reproductive health rights agenda. In addition, the development and accomplishments of U.S. women-of-color health rights organizations have made a significant impact on the women's health and reproductive rights movements.

In spite of these achievements however, health issues for women of color populations are still often treated as marginal by the mainstream reproductive rights and pro-choice movements in this country. By creating a women of color coalition for reproductive health issues, women of color organizations can work as equals with counterparts from mainstream, long-established reproductive rights and women's health organizations to set an agenda which fully incorporates the health issues of women of color.

THE IMPACTS OF POVERTY

The United States is perceived as one of the richest countries in the world. However, a large segment of its people-of-color communities suffer from historical inequities which have never been addressed in a systematic way. Poverty is rampant in many African-American rural and urban populations, as well as in many sectors of the Latin-American and Asian-American populations. Some

Native American reservation communities' unemployment rates are over 50 percent. In some reservation communities in Alaska, more than 60 percent of the population live at or below poverty levels. In urban inner cities, African Americans and Latin Americans have unemployment rates double to triple the national average. Latin-American and Mexican migrant farm workers in the agricultural farmlands in California and in states in the Northwest and Southwest receive below-minimum wages and live in substandard housing. Mexican and southwestern factory workers suffer slave-like conditions and are subjected to daily environmental health hazards. Newly-arrived immigrants and refugees from Indo-China, the Philippines, Bangladesh, Sri Lanka, Pakistan, Taiwan and Korea also work under slave-like conditions in low-wage employment, such as garment factories and electronic assembly plants.

For women of color, particularly single mothers, poverty means substandard housing, inadequate nutrition and high rates of chronic disease and stress. Women of color have shorter life expectancies, experience higher maternal and infant mortality, have higher incidents of chronic diseases and HIV/AIDS, due in part to their lack of access to a health care system. African-American women die of cervical cancer at three times the rate of White women, and die an average 5.5 years earlier than White women. Native American women have diabetes at twice the rate of White women. Chinese women are twice as likely to die from lung cancer as White women. Excessive cases of Hepatitis B among Asian women are 20 percent higher than among White women.

REPRODUCTIVE HEALTH ISSUES

Women of color populations also experience sterilization abuse, inadequate access to abortion, enforced birth control methods, punitive reproductive health policies such as the Hyde Amendment, and exposure to work place health hazards.

The National Asian Women's Health Organization, along with other women of color organizations, has carefully followed the widespread introduction of contraceptive technology, such as Depo Provera and Norplant. We are very concerned with the potential and actual abuses of these methods. We have seen the experiences in the United States of women convicted of substance abuse during pregnancy, or convicted of child abuse and sentenced by the courts to Norplant implantation. Incentive programs offering cash for implantation specifically targeted at poor women have been proposed in 17 states since the approval of Norplant in 1992. Pregnant women of color who abuse drugs are ten times more likely to be prosecuted and have their children taken away than White women, even when they abuse drugs at the same time.

HEALTH ISSUES OF ASIAN-AMERICAN WOMEN

According to a report published by the U.S. Commission on Civil Rights in 1992, "Civil Rights Issues Facing Asian Americans in the 1990s," Asian Americans are cited as having serious health care needs that are not being met. This situation is illustrated by the case of recent immigrants, especially those from the Southeast Asian countries. Inadequate data hinders an examination of the health status of Asian Americans. Because Asian Americans comprise a relatively small percentage of the population, national and local health surveys have not until recently identified Asian Americans separately, let alone by various ethnic subgroups. Since data regarding Asian Americans' health status has been virtually nonexistent, public policy makers and health care professionals have largely ignored or misunderstood the important needs of these populations.

Mental Health

Mental health concerns cross ethnic, class and generational lines within Asian-American communities. Statistics regarding the mental health status of Asian Americans are startling: elderly Chinese- and Japanese-American women have the highest suicide rate of all racial and ethnic groups, including European Americans. A 1987 study of 2,800 Southeast

Asians conducted by the California State Department of Mental Health revealed that 95 percent of them needed psychological help, compared with 33 percent of the population in general. With both immigrants and American-born populations, there is often a stigma associated with mental health issues and discomfort in discussing emotional problems. The high suicide rate among elderly Chinese and Japanese-American women has been attributed to anxiety, depression and the "displaced homemaker syndrome" that might have been resolved if these women could have sought culturally appropriate therapy for their emotional distress. High suicide rates among Asian-American children have been attributed to pervasive racism, pressures to live up to stereotypes, and expectations of high academic achievement. For immigrant children, assimilation is an especially stressful experience. Children of immigrants are at high risk for developing mental health problems, as they must relate to two cultures - one at home and one in the broader society.

Cancer

As with the population in general, cancer is a major health problem among Asian-Americans. Cancer of the cervix is more pervasive among Chinese and Southeast-Asian-American women than for European-American women. A California study of 167 Chinese-American women revealed that 68 percent had no knowledge of the purpose of a Pap smear and 69 percent reported no understanding of mammograms. Even though Asian-American women are the most likely to have health insurance among women of color in the U.S., they are the least likely to have an annual physical, the least likely to have ever had a Pap smear, and the least likely to have ever had a mammogram.

Violence

Health, public health, along with medicine and disease, needs to include all the elements that impact an individual's overall well-being. For instance, gender-based violence, including rape, domestic violence, mutilation, murder and sexual abuse, is a profound health problem for women across the globe. And although gender violence is a significant cause of female morbidity and mortality, it is almost never seen as a public health issue. Gender-based violence also represents a hidden obstacle to economic and social development. By undermining women's confidence and compromising their health, gender violence deprives society of women's full participation, contributions and skills. Each year, countless numbers of Asian-American women are beaten, raped, verbally abused and murdered by their husbands, boyfriends, and other family members. The vast majority of these cases are not reported, leaving victims trapped in physically and psychologically abusive relationships. The "silent crisis" of battered Asian-American women goes unrecognized.

The case histories of abused Asian-American women illustrate the intersection of culture, legal barriers, racism and sexism. Mrs. X immigrated from Hong Kong as a conditional resident, meaning that her legal status was dependent on her husband. Upon her arrival in New York, Mrs. X's husband and in-laws locked her in a room and deprived her of food, often for days at a time. Like many abused women, Mrs. X hoped that her situation would improve and remained with her husband and his family. After several months of deprivation and isolation, she decided to leave. In her attempt to escape, she fell out of a second story window and was hospitalized. Upon her recovery, Mrs. X left her husband, but was forced to attain "illegal" status because of her conditional residency status. Although she was counseled to file for an immigration waiver, she refused, fearing deportation. Current immigration law allows for battered immigrant women to leave their husbands and still retain legal status in the U.S. The law, however, requires battered women to document their abuse with affidavits from police, judges, medical personnel, school officials and social workers. In the course of leaving her abusive situation, Mrs. X suffered from extreme depression that was rooted in her "shame" over a failed marriage.

Perhaps no case better reveals the problems confronting battered Asian-American women

in the criminal justice system than that of Dong Lu Chen, who beat his wife to death with a claw hammer after she allegedly admitted to having an affair. Chen, in a "cultural defense," successfully claimed that he had been driven to violence by traditional Chinese values about adultery and was sentenced to five years probation.

Occupational Health

Another element usually not recognized as a health issue is occupational health. The U.S. recession has seriously affected the working conditions of Asian-American workers. With the availability of unskilled jobs in the U.S. shrinking drastically, non English-speaking immigrants often are forced to work in exploitative underground economies that have mushroomed in Asian-American communities. Consequently, like other immigrants who take these low-wage jobs, low-income Asian immigrants encounter difficulty in obtaining affordable health care, usually receiving little or no medical insurance. Securing affordable health care for Asian immigrants, especially Asian women, is further complicated by language and cultural barriers.

The garment industry in particular, the economic backbone of Chinatown, exemplifies the occupational health hazards endured by immigrant workers. Recently arrived women from China, the Philippines, Southeast Asia, Korea, Taiwan and Hong Kong constitute a large part of the labor pool. Eighty-one percent of the work force is women, the highest percentage of women in any manufacturing industry. The garment industry relies on a large, low-cost work force.

Most seamstresses are paid by piece rate. Under this system, garment workers may work well over 40 hours a week, yet only earn from $3,000 to $6,000 annually, despite federal regulations guaranteeing minimum wage. The conditions under which these women work rival those of 19th century sweatshops and often result in long-term health problems which can be compounded by lack of health insurance.

Exposure to unsafe levels of airborne contaminants, such as cotton and synthetic dust from formaldehyde, is exacerbated by poor ventilation. This frequently leads to lung ailments. Child labor, a clear violation of federal labor laws, is becoming an increasingly common occurrence in the garment industry. Not only does child labor increase the amount of piecework a woman can complete, it also covers the problem of child care while both parents work.

Another common violation in the garment industry is nonpayment of wages. Factory owners, citing the recession and the flight of garment production overseas, often withhold wages. Such severe exploitation is possible because new immigrants are easily intimidated. Unaware of labor laws, workers often fail to realize that they are being abused or that regulations are being broken.

CONCLUSION

We, the Women of Color Coalition for Reproductive Health Rights, are here to speak out against violations, abuses or denials of women's rights, and to advocate for more socially just economic and social development policies, which all impact on a woman's overall health status. In looking to the future, governments have considerable power to improve the health outlook for their female citizens if they are willing to enact and promote gender inclusive policies and to strengthen women's health services. Effective policy reform must include not only changes in the health delivery system, but also efforts to redress social, educational and economic inequities. Resources should be made available to eliminate both the internal and external forces that adversely impact families, e.g. inadequate access to education, health care and shelter, as well as political, social and cultural oppression, violence, war, racism, classism and sexism. And finally, women of color must be equal participants in the decision-making processes on all issues concerning environment, development and population activities.

Based on the fact that U.S. women of color's

perspectives were excluded from policies made at previous world population conferences, we resolved to express our position and concerns this time around. This is why we formed the U.S. Women of Color Delegation to the International Conference on Population and Development. Twenty women of color represented this delegation in Cairo, where we made a significant impact and our language recommendations were included in the final UN Programme of Action. A position statement on issues of population, reproductive health and sustainable development which reflects the women of color communities is available.

The members of the Delegation and the Women of Color Coalition for Reproductive Health Rights are all activists and are employed by regional or national organizations that work to empower women and people in our respective communities. We will continue to advocate collectively and in our own organizations to ensure that the voices and issues of women of color are heard and to ensure our needs are addressed in the national and international forums.

Special Session

Special Session

"Healing Our Inner Selves"

Cecelia Fire Thunder (Oglala Sioux)
South Dakota Department of Health and Medical Services
and
Theda New Breast-Ramos, M.P.H. (Blackfeet)
The Circle, Inc.

(Note: The following presentation was printed from a direct transcript of the proceedings and has not been edited by the presenters.)

Cecelia: First of all, I would like to greet you in my language. (In Lakota) "I greet you all with a warm hand shake with good feelings from my heart."

Theda: Cecelia and I think so much alike. When we were coming here, I said, "You know Cecelia, we're recovering wizards, everyone expects us to fix things," and we looked at each other and both said "huh?"

We got up early and went for a two-hour walk this morning to walk and pray. We prayed for all of you so that we could all be in a good way with each other today.

My English name is Theda Newbreast-Ramos, but that may be changing soon. I'm another woman in transition. You know, when you make that last dip through your addictive relationship, you sometimes have to toss a person to the side. My Indian name is Oakstokoma, and that's my real important name. My grandma named me when I was about four-and-one-half. I had a purse with a bunch of papers in it, and she named me that because Oakstokoma means a mole or a mouse-like being. Moles are never caught off guard, they always have a lot of food for winter, and they're always busy. She saw those characteristics in me, so she gave me that name. I hold my name dearly and honor how much that means to me in my own spiritual journey home within myself and my own physical journey home to live and stay on my reservation.

Cecelia: My Indian name is literally translated, "good-hearted woman," but actually, it means a positive-thinking woman. I was given the name before I was five. My elders looked at me as I grew up, and they could determine what type of character or person I was going to be, and they gave me a name that guided me no matter where I went.

I'm 48 years old, and I'm really proud of it. I just had a birthday, and the best part about being 48 is that my waistline and my age are catching up - balance and harmony. After you get to a certain age, you don't care whether you have a waistline or not. I mean, you have a good heart. People love you. That's all that matters. I've given up wearing Wranglers, but they told me they have polyester stretchables now. Every time I put on a pair of jeans, when I walk the other way, I look like a burrito. All kinds of bumps. I also found out that if you wear tight jeans, you can't breathe. The other thing is, when you wear tight jeans, your legs don't work as well. It just cuts off your blood supply and your toes turn blue. Then, after a while, your legs cramp up. It's better to wear big, old, nice stretchable-waist skirts.

Theda and I met back in the 70s in California. We're both California kids. I went to Los Angeles in 1963 on relocation. In 1967, I moved to San Diego, until 1987, when I came home. I went back to my home where I belonged, where my heart is. We're urban Indian girls, and we're reservation Indian girls. So we're all-round. Like an all-round cowboy.

Theda and I share our relationship with women of color. Living in Los Angeles and

San Diego, we worked together - African-American women, Asian-American women, Mexican-American women, Indian women, all kinds of women. We were all at the same place, helping and supporting one another. We considered ourselves bicultural, and at the same time multicultural because we lived with people of many different nationalities, backgrounds and races. Through that experience, we were able to see the world a little bit differently than some of our relatives back home on the Indian reservation who only see the world through one lens. Those experiences have also helped shape and guide us in how we see the world and have defined how we are able to translate our experiences for the people in our community.

Theda: What takes our energy? How many of you can identify with those spinning plates that you see on poles in circuses? Just as one is just about ready to topple, the magician adds a couple more? It is easy to get overwhelmed!

I'm 38 years old, and Cecelia and I are like sisters, but sometimes Cecelia feels like my mother, and sometimes I feel like her mother. In my culture, we really believe that the way to learn is by sharing each other's story. So to begin with, we were thinking of stories that have impacted many women of color, and I knew I wanted to share the Seal Skin Story with you. Imagine our great-great grandmother was sitting on her mother's lap. Now I know this story best from the Alaskan Native version. However, the story is also told in other parts of the world — by Scottish people, by any people who lived near the ocean or near the water.

> **The Seal Skin Story:** A man chooses to live like a hermit. He chooses to go out and live by himself, and to make his own dwelling. He's a hunter. He has his own canoe. He makes his own weapons to hunt with, and he stays by himself because this is what gives him comfort. He has total control of his environment. Something happens to this hunter as he stays out in his dwelling. He starts to yearn for human companionship. He starts to want to have a conversation with another human being. He starts to want to see another human being. He starts to miss the companionship of a woman. This feeling creeps up on him, and the more it creeps up on him, the faster he tries to go and the busier he tries to keep. He goes out before the sun comes up and he hunts all day. He checks his traps. He comes home, he prepares his food. But that feeling comes to him. When this feeling comes, it hits him in his stomach, in his soul, in his spirit. It's like he's so sad that he wants to cry, but he can't let the tears come.
>
> So this man lives like this for a while. One day, while in his canoe, he decides that he's going to hunt this one area. But he finds no fish. He not only has nothing to eat, but that feeling starts to creep into him. It starts to come into his stomach - it's like he's thirsty. He's thirsty to hear another human being talk. As he's feeling this thirst for another human being's companionship, he hears this sound in the distance. It starts to give him goose bumps, like it's giving me right now. It sounds like whales singing. So he's drawn, almost magnetized, to where this sound is. As he gets closer to where the sound is coming from, he remembers the stories of when he was growing up about the seals that could take off their seal skins and become humanlike. Because as he looks over, he sees the sound is coming from a group of naked women who are dancing on the rocks. They are frolicking. Their hands are frolicking. It's almost like their feet aren't touching the ground. They're dancing, and they are playing, and they are laughing, and they're hugging, and they're having a wonderful time. He's so mesmerized by the sound that they're making, he drops his oars. He's just not paying attention.

As he gets closer, he sees where they've taken off their seal skins. These are those beings that he heard about in legends. As he gets closer, this yearning, this pain that he feels inside grows, and he says, "I want one of them." So he takes one of the seal skins, and he hides it under his parka. As they finish, each goes over and puts on her seal skin. They jump back into the water and they return home. But one tall, beautiful woman continues to walk around, looking for her seal skin. She can't find her seal skin. He comes from behind the rock, and he says, "I have your seal skin." She looks into his eyes, and being the creature that she is, she can see his pain. He says to her, "If you come and be my wife for seven summers, I will give you back your seal skin". She looks into his eyes and being the compassionate, nurturing, loving being that she is, she agrees.

So they live in blissful love and harmony for the first two or three years. They have a child, a son. They're companions. They talk and they listen to each other. But something starts to happen in the fourth or the fifth year. She looks at herself and her skin is very dry, it begins to crack. Her eyes that sparkled are beginning to get dull. As time passes, she finds herself groping along the wall, because she can't see very well. She was a pleasantly plump, voluptuous woman. She has now become skinny (you know, like when you're on low-fat diets). She goes to her husband and asks, "Can you give me back my seal skin? I need my seal skin, or I'm going to die." He says, "No." He says, "No, I can't give you back your seal skin. If I give you back your seal skin, you're going to leave me." So it sets the drama. What happens from that point is a dynamic between the man and the woman - of him berating her, of her asking for her seal skin back, asking for what she needs, and him saying no. So this cycle goes on and she cries herself to sleep night after night.

The young son hears this, and he wants to do something because he loves his mom. He cries himself to sleep, and he dreams. He hears his name, "Akook, Akook." He wonders "Am I dreaming, or is this real?" He gets up out of his bed, and he realizes that the sound is real. He goes down to where the sound is coming from. It's coming from the water. As he walks up to the water, all he sees is this big gray-haired seal. The big gray-haired seal tells him, "Akook, you must get back your mother's seal skin, and give it to her or she will die. I will tell you where it's hidden." So he tells him where it's hidden. Then the young man has a dilemma. He thinks, "God, I've gotta get my mom's seal skin back - she'll die. But if I give it back to her, she's going to leave," because that's what he's heard. So finally, he struggles with himself and he decides to go get the seal skin. As he goes to where it's hidden, he finds it folded. As he unfolds it, he smells it, and it smells like his mom, and the smell goes through him, and it tingles through him, and he realizes it's her soul. He realizes he'll never lose her, because she is in him.

So he decides. He takes the seal skin, and he brings it to his mother, and he gives her back the seal skin. And she takes it, and she immediately puts it on, and she feels better. Her eyesight increases, and she just feels better. And then as she's feeling better, she gets cautious. She says, "We have to go. If we stay, your father's going to keep me as a prisoner." So they leave. She takes air, and she breathes air into him and they go down underneath the water. And when they get down there, the other seals say to them, "It's not his time. We'll give you seven days, but you must send him back up." So they eat together, they hug

> together, they love each other, they "be" together. But ultimately, they spend the last day crying because they have to take Akook back up to the earth-world. Now Akook is taken back up.

This story is frequently told over days and weeks. Since we're not going to be together, I've told you a short version. Wouldn't it be nice if we were together for days and weeks, just kind healing together as women? Each of you, as you hear that story, will have your own feelings and your own reactions. That is for your Spirit to decide. As Cecelia and I talk, we'd like to share with you how we've found our seal skins and how our seal skins were almost taken away from us as Native women.

We're looking at all those who own a part of us and who take our energy. No wonder our seal skins fall down around our ankles sometimes. We would like you to think about how you are working on healing, so that you can keep your seal skins and be with your families, and be with your communities, and be with your work. How do we do that so that we feel okay?

Cecelia: A friend of ours who used to live in Washington, D.C. recently packed up her bags and her kids and moved back to her reservation because she was losing her seal skin. She felt she was losing everything she believed in, even herself, by living in Washington, D.C.

I don't like the term minority, and I'd like to try to get it out of our language. Minority implies a condition of "less than" - I'm sure not less. I've got plenty here. So maybe a part of the objective for the next three days is to redefine who we are, and use a much more compassionate term to describe who we are.

My own journey has been to try to determine *what went wrong*. That's the bottom line. When you look at the condition of our community, be it inner-city, small-town America, or Indian reservation, there are a lot of things that are wrong. And everybody wants to find solutions for what's wrong. We pass legislation. We pump money here and there to try to correct what's wrong. On my own journey, I used to try to fix what was wrong. I realized eventually that I absolutely have no power to change the world. It's so messed up and crazy. I can't fix the United States. Look at all of the problems we have in our own country. Of course, I can't fix South Dakota, nor can I fix Pine Ridge reservation. Then I came to realize I couldn't even fix my own family. One day, I realized there's only one person I can fix: me. The only power I have, and the only thing I can fix, is myself. That's all! This is where the answer lies. We have to work from within outward, and not outward in. The answer lies within each and every one of us. The answer lies in the willingness to take that journey, to come to a place of balance and harmony within myself. As I become well and balanced, my vision changes. My world changes. I see things differently. I feel differently. If I love, honor and respect myself, all of me, then I'm able to love, honor and respect other people. So love and honor begins here first.

We talk about all of the "isms" that we have to deal with - racism, sexism, homophobia. We can't shake the magic wand over everybody and just say, "After today, we're all going to feel good about everybody, we're going to love and honor everybody." It doesn't work that way.

So as I began working more and more on me, and began to understand who I am, I was able to see my community in a different way . One of the things that we have to recognize (and it's probably the hardest part of being a woman of color) is that all of the things that happened before, whether it be our great-grandparents and our grandparents, all the trauma that's ever happened to us in communities, in our race, affects us today. We still carry the pain of all the generations that went before us. Yet, we have not taken that knowledge and translated it into the norms of the communities that we come from, so that they, too, can understand what it is that is being talked about here, and how those things play a great role in the wellness of our communities.

When we say wellness, it has nothing to do with physical wellness. It's the entire mind, heart, body and spirit.

The spirit is a very integral part of our balance. Everybody talks to the Creator in their own way. Everybody identifies the Creator in their own way. I've always heard that I was made in God's image. I said, "Gotta be an Indian woman." Wouldn't it be a great big surprise if God was a woman? And, of course, She is, because I'm a spiritual person, and how we each relate and talk to the Creator in our own way is the best way. If I feel that when I talk to the Creator, she's an Indian woman, I'm going to tell her the truth about how I feel. While talking to a man, I'll say, "It's none of your business." Each of us has our own spirit inside of us. We know that. So not only do we have to nurture our minds, our hearts and our bodies, we've got to nurture our spirit, too. Because it's that spirit, the strong spirit, that sustains us and gets us through the worst times of our lives. I'm sure, collectively in this room, there are many, many stories of trauma and pain. There are many, many experiences of trauma and pain. Without a strong spirit, would you have made it this far in life? I don't think so. Part of what we have to do in women's health is not only talk about reducing our risks of cancer and diabetes, we've got to be talking to our sisters about our spiritual well-being and helping all of us recognize the importance of that spirit.

Theda and I used to close Indian bars in San Francisco, in Oakland, and Los Angeles, and when we were out there, we were lost and lonely. We had our share of partying and of being abusive mothers. And I'm a recovered child-abuser. I abused my children in many different ways. As we begin this journey in forgiving ourselves, we are able to tell our own stories. We are able to share with other women that we've been there. But we've been able to transcend it, mostly by forgiving ourselves, and asking the Creator to forgive us, and that's all you have to do. It doesn't matter what anyone else thinks about you. As long as you love yourself, you know the Creator loves you. To reach that point sounds simple, but it is hard. As we began to understand more and more of what went wrong, we were able to translate it and put overheads together. (How many of you have taken Transparency 101?)

We've been working at different levels across the nation with other Native people, and we've had an opportunity to spend time together, and just talk and talk. Through that talking and processing, we were able to find those things we have in common, whether in the Pacific Northwest, the plains of Montana, the Southwest, with Navajo or Hopi. We have so much in common as Native people, that Theda and I were able to translate our individual experiences into tribal life experiences. We also noticed that all people of color have histories to deal with, traumas that we have all faced, whether it be your ancestors carried on those ships from the shores of Africa or witnessing whole villages wiped out. That's what we call cultural memory. You could be five generations removed, but that pain is still inside of you. There are many Indian people in Mexico. In fact, all of Mexico is Indian. Yet, people say they're Spanish. There are shame issues involved there.

I am an example of real diversity. I've got Indian, Lakota, Cheyenne, Crow, Mexican and French - just a really dynamic piece of person here. So I moved out of being ashamed of all of them to embracing the diversity inside of me, and acknowledging that everyone of those ancestors gave me the gift of who I am. Moving out of the shame and embarrassment of being a mixed blood to being a diverse person was part of my healing. Theda and I have taken this information, and we've translated it as much as we could to help other people come to terms with who they are. There has been much trauma and pain in our history - as a race of people, as a nation, as a community, and as a family.

Sometimes, we have to deal with the diversity issues in our own family. In my state of South Dakota, I asked some people last week, "How are we going to deal with the White-Indian relations when we've got to take care of our own relations and our own family?"

Half of my cousins look like White people, and the other half look like Indians, and we have lateral oppression. We oppressed each other because some are lighter and some are darker. In my language, we even have oppressive words and descriptions. In Lakota, we differentiate those who are dark and those who are light. In my growing up, more value was placed on those who were lighter. Those who were lighter received much greater attention and nurturing and guidance than those who were darker. So if you were dark, you weren't as valuable. So we begin to understand all of this stuff, and to start working in our own communities to understand and get our people to heal from the pain of trauma. We begin to come to terms with diversity within our own communities and families and to understand the trauma of our nations.

In my community, we have a trauma called Wounded Knee, the wiping of tears. In 1976, we had another Wounded Knee, the 1973 takeover. It's been 21 years, and that movie *Lakota Woman* opened up old wounds when we were starting to heal. So we have to have another wiping of tears. Here again, there are no winners or losers in my community. We have to learn how to develop the attitude of win-win and move forward if we're to be a healthy, strong nation. My nation must heal the wounds of all of those things - Wounded Knee, the onset of boarding schools (a tremendous disservice and pain was created because of the boarding school era), the TB epidemic.

When we look at all of those things, our community needs to know what we know. They need to learn to cry and grieve and let those pains go. As we become well, we must go back into our communities and let them know what we know. And we're going to make them cry, and we're going to make them laugh, but most importantly, they're going to let go of some of the stuff that they've been carrying around for generations and generations and generations. That's what we mean when we say we've got to begin healing. I think that we can lead the way. I think we have been leading the way.

Theda: What takes your energy and how do we take care of ourselves, and what do we need to be okay? How many of you think about your healing around your biculturalism? We've been educated in the mainstream and alienated from our own people. As Cecelia and I travel around, we hear stories from women, and we share some of our own personal stories because there is power in them.

I like to talk about the bicultural person. I was born and raised on my reservation until I was about eight. I thought the whole world was Blackfeet because I saw no Black people, no Asian/Pacific Islanders, Samoans, Latinos, Cambodians - the 54 entities that we stuff under that label. I saw very few White people, and what I was told about them, I didn't like. My mother and father were 16 years old when they married. My mother was 17 by the time she had me and that was normal. She had all five of my brothers and sisters by the time she was 22 years old and that was normal. I was reared by my whole extended family. I had many, many parents. Now I can look back on that and feel very, very grateful for that, because I had Grandma, Grandpa, Grandma, Grandpa, Uncle, Auntie, Uncle, Auntie, Uncle, Auntie, Auntie, Auntie, Auntie, Uncle, Auntie, cousins. We went on relocation to Oakland, California, in 1964, with dreams of a better life. My mother thought California would have orange trees everywhere and everybody would be out on the beach. She got off the train with five children (my youngest brother was 19 months old), very little money, and our stereotypes. The taxi driver took us for a ride so he took most of our money. I remember my parents had something like $11 left. We stayed in a hotel for four or five months because the relocation agency hadn't found us a place to live. Just saying this I have to take a deep breath.

I want to encourage you to take a look at your own bicultural journey, because I had blocked out what it was like way back there. I came home from school, and my mother found me in a fetal position, sobbing behind the door. She said, "Nellie, what's wrong?"

(She calls me Nellie.) "What's wrong?" I said, "Mom, there's no...there's no Blackfeet kids at that school. Everybody's Black at the school. There's no Blackfeet." I cried out to her, and what I was experiencing was the first internal pain that a bicultural person experiences. I was looking for my people, and they weren't there. (It's okay to cry. We cry a lot. We were talking about getting tattooed eye liner because we cry too much to even wear eyeliner any more). I share that with you because that's part of who I am.

I grew up in mainstream culture, and I am many things. I'm a recovering alcoholic. I'm a recovering codependent. I'm a recovering violent person. My last violent act was April 6, 1982, and I'm proud of that. I had such internal rage. I had such rage - not only my own, but my parents' rage, and my grandparents' rage - that I would act it out. I share these things with you because our healing depends on our acknowledging the stories. They're stuffed in there, and they won't manifest themselves.

For the longest time, I learned to shut down my feelings. I was the oldest child. I quickly became the other parent. When I was 12 years old, I used to go get the food stamps - got $112. I planned the meals for two weeks. I had spaghetti twice. We always had spaghetti twice. I went to Frye's market - we got the groceries - I had all the meals planned, and I cooked those meals, and I was 12 years old. That's when my father's alcoholism started to escalate. I realize now that my father was trying to numb his pain. He wasn't a bad person. He's a good man. He's a good person, but I didn't know that at the time. I realize, too, that my mother was trying to numb her pain. I see that now. I see my mother, and my mother is wonderful. If I could be half as good as she, or half of what she is, my life would be fulfilled. My mother told us stories eventually, and we remembered them. At first, she couldn't tell us, because she blocked them out. Alaskan Native people have this word for it. They call it "pretend it never happened." Pretend it never happened, but my mom began to share with us.

She was five years old when they took her away to boarding school. She spoke no English, the teachers wouldn't let them speak their language. Her hair was cut. I can remember Aunt Mavis telling me that because her skin was so dark, the nuns used to scrub her with bleach to whiten her up. My mom is a community organizer, and was when she was nine years old, too. She organized a break. She and several of the kids at boarding school got their blankets and their food, and broke out. They didn't go back home because they knew the superintendent would go to their houses and make the kids come back. They made the break because they couldn't rely on their parents, and they weren't going to stay in boarding school. They were able, in the middle of winter, to survive for more than three weeks. Finally, they sent out search parties.

I want to tell you about my mother now, about what she's doing. Cecelia and I are part of a team of about 30 Native people. Marjorie Bear Don't Walk is part of this team. We've learned how to facilitate a healing cross called the Gathering of Native Americans - the GONA. One year ago today, we were doing the pilot of this healing in Nevada. I said "Mom come up, take a break." She's director of an American Indian family healing center, which provides traditional healing and a 12-step therapy for Indian women and their children. She built that program. I said, "Mom, you need a break." One of her learning steps is to learn how to take a break. I said, "Why don't you come up, they've got a great jacuzzi up here. I'll be working. We can have dinner together. You can just hang out." She said, "Okay." So she drove up.

It was one year ago today. I remember coming back to the room, and, of course, it had been a long day. Cecelia and I had been facilitating and all I could think of was, "Oh, just let me kick off these shoes and flop in the bathtub. I came into the room, and my mother was very excited. She said, "Nellie, guess what, guess what?" Now, I knew she couldn't be pregnant! She had a hysterectomy when she was 37. I knew I wasn't pregnant. So I said, "Well, what mom, what?" She said,

"I decided to move home! I was out there swimming in the water, and I looked up at the mountains, and I said, 'I'm moving home.'" I know my mother, and when she said this to me, I knew that this would, in fact, happen.

Since that time, she made a plan, she got her board of directors together and said, "Ya' all, I'm letting you know up front, I'm going to be leaving. But I'm willing to help you out, and this is how it's going to be done. I'm phasing-out and I'm done in June. We can advertise. We'll stabilize the program. We'll interview. I'll even train the person for a few weeks, and then I'm gone." Really proactive. Instead of, "Oh, I'm burned out, here's my resignation." So she did this. She followed through with the plan. It was really, really hard. Mom's return home to the reservation triggered healing within our own family. Dad has already been home. They have been divorced for 15 years.

Mom said, "Okay, I don't know what I want to do next, so let's see how can I get some money until I know what I want to do." So she did. She sold the house in California. She took out her retirement and signed up for unemployment. She said to me, "Nellie, no one lays on their deathbed saying, 'Oh, I wish I would have done more work.' They say all kinds of things like I should have spent more time with my family, I should have done this, I should have done that. I should have done this, and here I am dying and I didn't get to do it." She said, "I'm going to do everything, so when I'm laying on my bed, I'll have no regrets." So I said, "Okay mom, where are you going to go?" She said, "Well, first of all, I'm going to join that protest walk from Alcatraz Island into Washington, D.C. These are my walking shoes." (She bought these new walking shoes.)

On the way, she called me. "Mom, where are you?" She said, "I'm staying on Elvis Presley Boulevard across from Graceland. I've been watching Elvis Presley movies all day." (My mom loves Elvis. In her bedroom were pictures of us, but the biggest and the main picture was Elvis. This is the woman who managed to get a ticket when Elvis came to the Bay area. She went by herself. I remember before she left, we took all of our bloomers and our underwear, all which had holes in them. We gave them to her and put them in the bag to throw on the stage. She went to this Elvis concert and threw our old bloomers up at Elvis.) Well, anyway, my mother ended up telling me she went there because she believes Elvis was part Indian. That's the reason he had so much soul, the reason he knew gospel. So she even went to his house and smudged and prayed for him. She went to his house and looked at all of his collections and cried — cried for the Elvis that didn't get to live his life out. From there, she joined the walk.

I was working with Native Hawaiians and other indigenous people in Hawaii, and I said, "Mom, why don't you come over?" "Okay." So I pulled out those frequent flyer tickets, and I flew her over. She came over there and had a ball. She went to the island. She went to all the dances. She took all the pictures. She took in the museum. She laid out — she got a tan. One of the best gifts for me occurred on the last day. This couple was watching us, and they said, "My, you are such happy sisters."

As a result of her decision, she started walking every morning for one-half hour. She didn't change what she ate. She didn't do anything else. Somehow, 27 pounds just fell away somewhere. It just went somewhere. She has all new clothes. She has a new body. My mom looks great. She looks like my sister. She looks really, really good.

I share that story with you because I come from a line of strong women. I share that with you because my mother's stories, and her resiliency in spirit, I get from her. And these gifts are more important to me than some of the mainstream stuff that we judge each other by. I've earned a couple degrees from Berkeley. I was one of those SAT kids that got a perfect score in math. In the bicultural world, we learn how to do mainstream things, and we learn how to do our own traditional things.

What I ask you to look at is how you are healthy in each way, because over and over, I hear women say things to me like, "You know, they're having a ceremony back home, but I sure would like to take a vacation to Hawaii." Dilemma. You know, I feel weird when I pull out my credit cards around my relatives, because they don't even own credit cards. Those are the words of a bicultural person. A lot of our healing on the inside is becoming comfortable with ourselves and not feeling that shame that Cecelia alluded to earlier. I always think of this old timer who said to me, "You know, you're going to be at your funeral, and you're going to be laid up in your casket having your best outfit on. And people are going to walk by, and someone's not going to like what you're wearing." So get over it.

Cecelia: When I think about my own life, I'm always amazed that I'm here today. I could have been a statistic, and I could still have been living in downtown Los Angeles. I could have been dead. I could have been a lot of things. Each day I pray, I thank the Creator for today. I thank the Creator for giving me everything She's giving me to be here today. I always say the Creator had different plans for me than I did. Everything that happened to me - every experience I've ever had, every pain that I've ever had, and every pain that I've ever caused - were my teachers to help me do the work that I do today. Those were all learning experiences. How many of you were born smart, like I was? You were all born smart, doggone it. Now, not only were you born smart, but you were born good looking. How many of you were born good looking? Oh, yes.

A part of what we need to do is to shift that paradigm which always emphasizes education. Many of the best people who are creating change for themselves and their community are people who have no formal education, but just learned by living. It's people who have wisdom. People who have learned from being there.

We all carry scars from our past, don't we? The reason I wear long skirts is I have church knees. How many of you have church knees? I went to church every morning for ten years, and at that time, they didn't have those little plastic things that they put on the pews, so our knees got deformed.

We laugh. Part of the healing aspect of our lives is our laughter. We take those painful times in our lives, in our personal journey, our community's journey, and we laugh about them. In my community, there is a lot of laughter. I just love to be around my people and just sit there and laugh. They make me laugh. The winos look for me because they know I'll always laugh at their dumb jokes. People want to tell me things because they know I'll repeat them to make another person laugh. When we look at the kind of gifts the Creator has given us to help other people, the capacity to make people laugh and cry is a wonderful gift.

I used to be a mother on welfare. How many of you used to be on welfare? You tried to get by on food stamps and make your ADC checks stretch, and you couldn't figure out if you were going to pay the light bill or the propane. Out of that experience, we became awesome negotiators. We used to talk the gas man into not turning off our gas. We'd convince the electricity man, "Just give me one more day." Being on welfare and being poor, we learned to be the best negotiators and the best hustlers. Out of being poor, we acquired a lot of wonderful skills. This is what I do for my community and for women. Yeah, we've been on welfare. Yeah, we've been on food stamps. Yeah, we've been poor. But out of that, we've acquired some wonderful skills, haven't we? I was telling my son the other day, we should have a workshop, and bring all of the drug addicts in to teach us how to hustle and raise money. If anybody knows how to raise resources and where they are, it's somebody who is addicted to something.

Living in an urban area, I was always amazed at the number of people who have absolutely nothing, not a nickel or credit card. Yet, they could get a pair of shoes from the Salvation Army, or a $20 food check from another organization. They knew where to go to find

the resources. These are the people that we need to hit up to do workshops for us about where to find the resources. Write that down some place. They're the experts. Anyway, surviving while being a mother on welfare with two kids and no marketable skills led me to become a nurse.

Along the way, I did a lot of things that I'm not proud of. Along the way, I did a lot of things that I am proud of. I had to learn how to balance it. There's good and bad in everything we do. So today, at 48 years of age, I have a whole bunch of experiences to draw from, which help people in the work that I do. One of my greatest sources of fun right now is that I have my own radio show. I'm a disc jockey. I never thought I'd ever do this. The reason that I never thought I'd do this is that I'm hearing impaired and I wear bilateral hearing aids. I took a lot of risks. I have the most popular radio show in Pine Ridge on KILI. I do all kinds of radio programming. I say what I have to say to teach the people who are listening about what they have to do. It's interesting because it's normal and natural to say what I need to say. I think the other greatest fun I have is working, not only with our Indian sisters, but with other sisters of different races and cultures.

As I became healthier, I began to see my family differently. I have a couple of sons that are really, really two different people. My baby just finished a 90-day treatment program in the San Francisco Bay area. The thing that really hurt me about that experience was that he did it all by himself. He didn't ask me for any help. One day, he called and he said, "Guess where I am?" I said, "Where are you?" He said, "I'm in San Francisco." I said, "What are you doing up there?" He said, "I'm at the treatment program." I said, "Who helped you?" He said, "I did, nobody helped me." I've been one of those enabling mothers for a long time. I wanted to do everything for them. Yeah. Bail them out of jail. Pay their traffic tickets. Get them their driver's licenses back. He did it all by himself. I felt really bad. Now, he's doing really good.

Then I have another son. My oldest son. Oh gosh, I really have to love him. I have to pray really hard for him. He's getting better. It's amazing that I became less critical of him. I was able to say, "All I can do is pray for you. That's all I can do, and just ask the Creator to look after you." There was a time when I couldn't do that. I wanted to control everything he did. "Where are you going? What are you doing? Who are you going with?" He's 27 years old.

I am thankful for the grounding by my family that was established before I was five years old. My grounding and my establishment of who I am. My knowing who I am — my relatives, my clan, and my language. Only in the last five years did I truly appreciate what my mother did. One of the things that my mother never, never forgot was being a Lakota woman. In East Los Angeles, Spanish was spoken fluently. My mother never spoke English. She always spoke Lakota to us. I always remember going to all of the stores on Whittier Boulevard. We used to go into this one department store, and even though everybody was speaking Spanish, my mother never spoke Spanish. So we used to shop, speaking our language, and everybody in east L.A. that spoke Spanish would stop and listen to us. They would say, "Where are you from, the moon?" It was like my mother, even though we lived in East Los Angeles, she never let us forget who we were. She did that by always speaking the language. She always sang to us. She taught us to sit down and sew. She taught us to do bead work. She taught us all these things that we needed to know as Lakota women in East Los Angeles.

I grew up in a community like Theda did, where I thought the only people in the world were Lakotas. Then there were these White people that lived around us. Then I went to Catholic boarding school. I didn't think those nuns were human, because at that time, all I ever saw was their little round faces and their little hands. They used to be covered up. I thought they never ate or slept. They used to have eight hundred keys. They always had these keys. There was a key for everything. They locked everything. I used to think that they took this big key, and they went to a

closet someplace and stood there all night. In the morning, they stepped out. The first time I saw a nun take a drink of water, I went, "Oh my gosh, she's drinking water."

How many of you are bread addicts? Oh, come on. I love bread. You see my body does not have one ounce of fat. It's not fat, it is dough, with all the bread that I eat. When Theda and I were driving around, I remembered when I went to Catholic boarding school, we ate three square meals a day. We didn't have a pop machine. We didn't have a snack machine. We didn't have quarters. Even if there was a pop machine, we couldn't buy pop. They used to feed us three square meals a day. Because it was a Catholic boarding school out in the middle of the boonies, we also raised our own cattle. We always had beef. At noon, we always had meat and potatoes. The meat was really, really good, because it was home grown. At three o'clock, the bell would ring. Bang, bang, bang. We had a bakery. They baked their own bread. At three o'clock, we all lined up. From the bottom of the bakery came these big tin cans full of fresh hot buns. We'd all line up for our buns, and it was fresh and hot. Oh God, that bun used to last for an hour. I took my time eating it. I savored every bite. Just loved it. Today, I still think that my addiction to bread has a lot to do with that time. Now I can eat more than one bun. I buy the whole loaf and put a lot of butter on it and eat it.

Everything that happened to us in the past is connected to what we are doing today. At that boarding school, they took away from us some very important skills. For ten years, I was at that boarding school for nine months every year. For ninety months, they had me. For 30 months, my parents and family had me. So who do you think had the greatest influence on me? They did. They had the greatest influence on me, and they truly, truly damaged some things: my mothering skills, my parenting skills, my relationship skills. All of those things were affected because they separated us — boys were over here, and the girls were over here. We never had a chance to communicate and learn to have relationships. Even if we danced with boys, they made sure there were 14 inches between us. We had to dance like this. Even today, I still dance like that.

When we look back, it's not to blame, it's to understand when it happened and where it happened, so you know what you have to do. That's what this healing stuff we're talking about is all about. As I went through my own healing journey, I said, "Oh God, finally I got rid of all of my bad feelings and my anger, and my hate, and my rage, and my frustration." No way. I found lingering things. I had to take care of my mother's and father's pain. My grandparents and all this other historical stuff was still there, and I had to take it one at a time to be able to get to a place where I could say I'm truly well. I am continuing to heal.

Our own stories are a great way to teach. It's real. How many of you know that? Be real. Be honest. Don't stand there and give me a lecture. Tell me about you, where you've been, what you've experienced. As women of color, we have so much in common.

When we talk about poverty - living in East Los Angeles, living in the big city, living on a reservation - there's so many similarities. When you're poor, you feel helpless. How many of you woke up and didn't have a nickel in your pocket? How many of you have been so poor you went without a nickel in your pocket? How did you feel? Pretty awful. Our work entails every aspect of our lives and their lives. How do we heal women who live on an ADC check of $130 for a whole month? What can we tell them? What kind of message can we give them to make them feel good about who they are? What kind of positive things can we be putting into their lives in that day? What can we do to make them feel good? I always think about the time when I was there. What did somebody say or do to me that made me feel good? What empowered me or just made that day a little bit better for me? On my radio show, I asked, "How many of you in the listening audience have been told that Pine Ridge reservation - Shannon county - is the poorest county in the whole United States?

Yes, I've heard that too, but go out of your door, look out, go outside. What do you see? You see land as far as you can see, and who does that land belong to? It belongs to you. Look inside your house and look at your children. What do you see? You see beautiful little kids looking at you. Some wonderful, beautiful human beings. And who made them? You did." I use this approach to make people feel good for that day. No, we're not the poorest nation. Look at all of this land that we have. According to a White male system, the wealthiest people in the United States have the largest land base. If that's the case, look how wealthy we are as Indian people. Try to turn it around when we talk about our own stories and we share where we've been with all of our sisters in our community. We begin to bring us together at a different place, and we begin to look at each other differently. Through sharing stories with each other about our pain, we help each other. The talking circle concept began in the Indian community, and it's growing.

We have been having our Indian Wellness in Women conferences for six years in Phoenix and Portland. Over 3,300 women came to our four-day conference. This conference has nothing to do with policy or legislation. This conference gives Indian women an opportunity to look at themselves physically, emotionally, mentally and spiritually. It gives them an opportunity to come to a place where there are other women who have been abused and who have transcended that time. It gives them an opportunity to hear the women tell their story. They are able to come to a conference where they hear other women tell about the horrific physical abuse they suffered at the hands of not only their parents, but caretakers. It gives them an opportunity to come to a conference where they can hear other Indian women talk about the violent lives that they've led, and how they've been able to transcend it. It's a conference where women come, and go to all these workshops to look at their minds, their hearts, their bodies and their spirits. We even have Sweat Lodge 101. We have Sweat Lodge 102, and we have Advanced Sweat Lodges. We bring our women together, and because we're so excited about how we feel, we want to share our excitement. We want women to come and spend those four days with us and leave with maybe one thing that they feel good about. Through that experience, we're hoping they go home and share that story with other women, and that they organize in their own community, and start looking at the whole issue of wellness. We have to find a forum to talk about this stuff. We have to be able to reach as many women as we can with the message that you don't have to live in an abusive relationship. These are things that you can do. And these are people and phone numbers that you can call. As we do this work, we take great risks. We take personal risks, but most importantly, we have to go out and lobby for that air time. Women came to our conferences two or three times to learn more about everything that we've talked about.

I'm an expert in alcoholism. Eighty percent of the men in my family are six feet under because of alcohol and the effects of alcohol, be it heart attacks or cirrhosis, or other types of physical damage that alcohol can do to a body. How many of you watched people die of cirrhosis? It's a very ugly death. So I looked at my family and realized the tremendous pain and trauma we've experienced. I now know that it's not the alcohol that's the problem - it is the human condition. My uncles and my dad, and all of my people, use alcohol as their painkiller of choice for the pain that they have inside. Earlier, somebody mentioned that we've failed to provide psychological help and mental health services to people in their own language. We have failed to provide those types of services using the norms of that community. In all the work that I do, I wear many, many hats. But the one hat that means the most to me is my ability to speak my language. I have a sister, and we used to talk about this. Wouldn't it be wonderful if we could have therapists on the Pine Ridge reservation who could sit in therapy and ask somebody something in their own language, versus asking them in English? If we had more therapists who could speak our language, we might have been able to prevent the deaths of some of my uncles and

aunties and cousins who are dead because of the pain. Would we save them if somebody had been there to ask them in their own language, "When you were a little child, did you experience any trauma?" Recently, I got to do that with my aunties. I did a process group and I got to facilitate my clan. That's pretty hard work. I did it all in my language. We talked about shame. I said, in Lakota, "We're going to be talking about shame this evening. Has anyone ever shamed you from the time you were born, and what did they do that made you feel that shame, and what type of pain did you feel?" We sat there for six hours. By asking in our own language, we were able to touch that pain inside. They were able to bring it out. We sat there, and we cried with each other for six hours. There were all kinds of shame that they were able to identify, and the pain that went with that. One the biggest pains that they had was that they were made to be ashamed to be Indian by somebody. They were made to be ashamed because they were dark. They were made to be ashamed because they spoke their language. When you're a little kid and it hurts you, where do you put that shame? Way down deep inside. I knew that they still carried that, and I wanted to find a way for them to share that. I took a big risk, and I said, "I'm going to do it. I'm going to ask them those hard questions in my language." Doggone it, we cried a lot. We still meet and we still cry. I'll tell you a couple of stories that I think you need to hear.

Myrtle speaks Lakota fluently. In our own kinship system, we address each other as cousins. We have names for male cousins, female cousins, and we use those terms to address each other. I said, "Auntie Myrtle, you've been very quiet. Is there something you want to share?" She said, "The shame, the pain of shame is so deep, we may never get rid of it in our lifetime if we don't work on it." The pain of being shamed is so profound and is so ugly that it can bind you and prevent you from becoming the person that the Creator made you to be. As she talked about it, she started telling some things that happened to her. I said, "How old were you when that first happened to you?" She said, "Oh, my girl, I must have been eight." I said, "How old are you now?" She said, "Seventy." So in that little group of older women, I've been able to practice something that I've always wanted to do in my own language - to get them to talk about shame - shame and how it hurt them. Through that process group, in our own language, we've been able to touch upon so many different things. One of the things that occurred to me today is that if only we had therapists or alcohol counselors that spoke our language with my dad or uncles. If only we had people who could understand the history of our people so they could ask the right questions in our own language, maybe my dad would be alive today. Maybe my uncle would be alive today, and maybe all of my cousins who died because of the side effects of alcohol would be alive today. The pain of my family, the pain of my past, is what energizes me, and gives me the vision and the direction to do what I have to do to help the next generation - to help myself - to help my aunties and my uncles who are still alive.

It's interesting that as my world view changed and I looked at the world differently, I was able to look at every alcoholic and every wino in my community and not label them as that damn drunk - or those old winos. They were human beings with a lot of pain inside of them. They were human beings. We never asked them in Lakota if they needed help. We never asked them if they wanted to talk. We just wrote them off because they were drunks, or alcoholics, or drug addicts, or street people. There are a lot of people with pain out there.

My cousin, before he died, would always say (in Lakota), "Cousin, two dollars. Could you loan me two dollars?" One day, I said (in Lakota), "Don't ever borrow money from me, because I know you never pay me back, so just say, 'Cousin, give me two dollars.' That way I'll give it to you and you'll never pay me back." He said, "Okay." He didn't ask me for a couple of months. Two months later, he said, "Cousin, five dollars." I gave him the five dollars. He turned the tables on me. Anyway, he got sick. He had cirrhosis. When

you have cirrhosis, your time gets shorter and shorter.

So one day I saw him, and I said to myself, "Practice what you preach, girl." So I honked and asked in Lakota, "Are you hungry?" He looked at me very strangely. I have never before asked him if he was hungry. I said, "Are you hungry? Get in, and I'll go buy you a hamburger." "You want me to get in your car?" I said, "Yes." He got in. "Are you sure I won't dirty it up?" I said, "No, it's okay, get in." He got in. I took him to a hamburger joint. He said, "Go in and order and bring it out." I said, "No, let's go sit down." "You want to be seen with me?" I said, "Yeah." We sat down. He was eating, he looked at me, he said in Lakota, "Why are you doing this?" I said, "Because I need you to forgive me." He said, "You've never done anything to me. You've always treated me good. You yell at me all the time because I'm a big drunk." I said, "Well, I want you to forgive me for not being a good relative. I want you to forgive me for never acknowledging you as my cousin. I want you to forgive me for being ashamed of you because you were the town drunk. I want you to forgive me for never offering you a cup of coffee in my house. I want you to forgive me for never reaching out to you and saying, 'LaVern, do you want to go to treatment? LaVern, come over and let's talk. Tell me about your life. What did you do when you were a little boy?' I want you to forgive me for not being a good relative — a good cousin. I want you to forgive me." He looked at me. He said, "I forgive you." Two weeks later, he died.

The story I shared with you shows the importance of valuing every human being in our community, the importance of recognizing the responsibility that we have for each other, recognizing the meaning of kinship and of being good relatives, of recognizing the meaning of reaching out. It was interesting because I never thought I would ask my wino cousin to forgive me. There was a time when I would have said, "What, you're kidding, he's just an old drunk." But this old drunk was a little boy at one time, and he must have gone through some hard times in his life. Things must have happened to him that made him want to numb himself day in and day out. I hope that this experience that I had with this one cousin will always remind me that they are my relatives, and that I should reach out and offer kindness, and generosity, and compassion. I told my sister this story. She was quiet for long time. She was crying. I said, "Are you crying?" She said, "Yes." She said, "You know when you asked him to forgive you? Was that a blanket forgiveness for all of us?" I said, "Yes, it was."

Theda: Cecelia reminded me of a story. I remember going home one time and asking grandpa, when I was first contemplating getting sober, "Grandpa, what do you think of these 12 steps — look at these 12 steps of AA." I read to him what they were, and he said, "Oh, that's very interesting." He said, "We always lived like that. You say some White guy wrote it down in 1935? That's pretty good." But at the same time, I remember something to honor our feelings together as human beings, as women in this room, and welcoming our men friends that came to join us. I had held back a lot of the crying because I wasn't letting the healing happen. I was stuffing it down deep. Finally, I was talking to Grandpa, and he said to me, "Oakstokomo, (he never called me Theda) your tears, my baby, my girl." He said, "You're like a tree - and your roots, they go out real far, and if you do not cry, what happens is you're calcified. You're a walking dead person. When your tears cry, they go all the way down, and they water all of those roots - all of your roots - and they let you grow and become the person you need to be."

Then I really let it out. I had been given the gift of permission to cry - and permission to heal. So give yourself that permission. We can do it together. We have a gift here as women of color, and women in this room, and human beings, to be together the next few days, to heal each other.

Cecelia and I were supposed to be presenting workshops at two concurrent conferences in Edmonton, Alberta. I would be doing one workshop, and Cecelia would run over and say, "What am I supposed to talk about?" And I would say "sexuality," and she said, "Oh, okay." How many of you are comfort-

able just saying words - parts of our body? What do we call the male anatomy? How do we refer to the female anatomy? How many of us are comfortable using the scientific terms to describe ourselves? How can we overcome our shame and heal without acquiring a comfort level? Cecelia and I use humor and laughter. Here we were at this conference, attended by about 80 people from 14 different countries, and by the end of that conference, indigenous people from all over the world had learned to be comfortable with their own bodies. What it provided for us as a healing conference and a healing community, was something that we could laugh at together. We could say some sexual terms and do some sexuality healing. I share that story with you because our sexuality is a part of who we are.

I am separated from my husband. I've only been married once, and it looks like he's regressing on his recovery. If it continues, I'll have to divorce him. It's painful. I have a dear friend who knows me well enough to understand my sexuality. She also knows that I'm a recovering addiction-relationship person, and that I used to go from one relationship to another, and that it's a mistake for me to wind up with the next one in the variety pack. That is a supportive friend, supporting me with my own sexuality while the two of us are going to counseling.

I am currently being counseled by this hard-core veteran. He works with hard-core Viet Nam vets. He's an older Indian man, and he doesn't let me get away with anything. I am, at the same time, seeing a counselor who is a Christian White male. He has helped me incredibly over this past year because he's a spiritual being and he's able to facilitate my spiritual growth. At the same time, I still go to my meetings, I stay with my friends. I have other friends in the audience here. Those are the kinds of supports that allowed me to have a real rough counseling session yesterday, come here today, get up and go walk, and pray and be with you - and not drink any alcohol or drop any pills. I share that with you because that is how we need to begin to share with each other. As I was making my phone calls and meeting my responsibilities, I was asking myself, "What do I really need to do, and what can wait until later?" I've learned these skills of taking care of myself. When I came down, I said, "This is why I need to be here with you, sharing my healing with you. Because that is how we all heal together." It's not just women of color, and it's not just women, it's human beings healing together. That's how we begin on this journey. As we were leaving home, I remembered a saying which I saw in one of my in-laws' kitchen. "Brilliant people talk about ideas, average people talk about things, and small people talk about each other." We have to talk about our healing journey, talk about the ideas, talk about things, but not talk about each other, and not judge how each of us does our own healing journey.

As an example, you know Cecelia and I went to the rodeo. As we were there, we were figuring out how to make it better for next year. We weren't saying, "They did that wrong - they did this." We were just saying "Oh, we really need to have a non-drug/alcohol dance for the teenagers." There was no dance for them, so they had nowhere to go. They were just hanging out. Then we said, "We need an Indian clown. We need an Indian announcer." We need to ask how can we energize each other in improving the health of women of color. All the answers of what we need are in this room as we sit. So as we can hold each other up in our resiliency and our brilliance, we can share ideas and reach out and go over and just extend your hand to another woman. Give her a hug and share your stories. That is how we begin, as a community of women, to heal each other.

Cecelia: Theda and I can say some of our best friends are women of color. We lived in California, and we maintain relationships with people that we used to hang out with. We still go visit them and they come visit us. We have come to realize that the stories of African-American women, Indian women and Hispanic women are the same stories. It's only when we get to know each other on a one-to-one basis that we truly appreciate who we are and where we come from.

There are many, many stories out there. I have a little friend about this high from Cambodia, and when she told her story, I just bawled. She still writes to me, and she's a therapist, and she does therapy in Cambodia. She realized that her relatives from Cambodia were really, really hurting. One of the things she realized was that they had to heal and grieve the loss of a way of life, and a loss of the land. As those American bombers dropped Napalm and bombs over Cambodia, they completely wiped out things that those people of Cambodia identified as home - a treetop, a tree growing on a mountain, the way the sun hit that valley as it was setting. Those of us who grew emotionally and spiritually attached to our land can share that pain. The common threads of our stories are the same. Our healing takes the same journey.

Keynote Presentation

Keynote Presentation

Maria Guajardo, Ph.D.
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Buenos Días. I was told that everyone was bilingual, so I decided to do my presentation in Spanish today. Con su permiso, voy a comenzar. Someday, I'll be able to make that comment and it will be true. It will certainty be a privilege. I'd like to thank all of you for braving the weather, for braving your schedules, and making time to come this morning, to spend this day together.

I was sharing with someone that last night, I sat down with the conference proceedings from two years ago at about 12 o'clock. I hadn't intended to read them, I was just going to look through them. And at about midnight, I had finished reading them again. I was so inspired. I thought, how could I not be here with you this morning! As I thought about it, and as I thought about the theme of the conference today, I thought about the challenge that we have before ourselves: healing ourselves as we do our work of healing our communities. I thought that what we need to be about is the work of developing our own sense of humanity. We need to begin to develop and create a strong voice within ourselves, and I want to share with you some thoughts about how that journey has been for me. What that's meant for me to find my voice in English, in Spanish. What it's meant for me to find my voice, and then to use that voice to discover my community's voice, in English, and in Spanish, because I do traverse two worlds. I speak in two languages. I think in two languages. I dream in two languages. And I'm not sure which language I dress in, but two worlds certainly permeate my existence.

So I want to share with you some thoughts about my journey. I want to leave you with some thoughts as you continue your journey throughout today, because I think this journey is not only about us individually discovering our voice and strengthening our voice, but it is also about strengthening our collective voice. We come together, I think, to discover a collective voice. It's easy to identify differences among this group. It's difficult to identify similarities. So I would like us to think about how we can, if possible - and I believe it is - identify a collective voice. Because our children need our collective voice today. Not tomorrow, and not in 50 years. Our children, our grandchildren, need our collective voice today.

DISCOVERING OURSELVES

In order to have that collective voice, each one of us individually has to discover, tap, and develop the potential of our own voice. Whether it's in English, in Spanish, in the language of your ancestors. Through your dreams, we need to discover that collective voice.

As we begin on that path of humanistic development, I look to other colleagues, I look to other friends, for their words of wisdom. Someone that I consider a friend, although I've never met her, is Sarah Lawrence Lightfoot. Sarah Lawrence Lightfoot was very privileged in receiving the MacArther Fellowship. She interviewed her mother, Margaret Lawrence, a child psychiatrist, one of the first African-American women to receive a medical degree in this country. In speaking to her mother (and I hope I can have the privilege of doing the same someday - to listen to my mother's stories, to listen to her voice), Sarah Lawrence Lightfoot listened to her mother's stories and her voice, and her mother said, "Know the long sweep of your own history. Know the values imbedded in your cultural perspective. Know the inner workings of your own people before you dare to ask others for

stories." Because what will happen, especially when we come together in a multicultural group like the one we're in today. It is very easy to look at each other and to stare and to inquire, and to fall into the "lookie-loo" phenomenon of, "You're different, tell me about you," "You're unique, tell me about you." We forget that the richness comes from allowing ourselves to share our own stories first.

I'm intrigued when people ask me where I am from. On a good day, when I'm in a positive spirit, I know what they're asking, and I know that in a novel way they are saying "Maria, you look different, you're not European American. You don't look Irish or Jewish, where are you from?" If I'm on the East Coast, people think I'm from the country of India. I may be Moroccan. I may be Nepali. If I'm on the West Coast, people absolutely think I must be Chicana, Latina, from a Central or South American country. As I was trekking through Nepal in the mountains of the Himalayas, it was wonderful to have people think I was either Tibetan or of that area. I think it's wonderful to fit in. I remember going to Morocco and thinking "I have died and gone to heaven because I look like everybody here!" It was the first time in my life that I looked like everyone around me. It was the first time I didn't stand out. Even in Mexico, I stand out. So when people ask me, "Maria, where are you from?", if I'm in a good mood and in good spirits, I share that my parents are from Mexico, and that they came as immigrants to this country with three small children in tow. And three more children were later born here, and I was one of the latter three. If I'm not in a good mood, and if I've had a hard day, and if something tells me this isn't a very sincere question, if I feel that the "lookie-loo" phenomenon has begun, I say "You're right I'm not from Denver. I'm from the East Coast. I came here to go to graduate school." And they look at me a little puzzled, a little intrigued. I remember a graduate school professor looking at me at a reception and saying, "But where are you really from?" I had not had a good day. So I said, "You're right, I'm not from the East coast. I did my undergraduate work there, but I'm really from California." His eyes got bigger. This was not good. He asked me one last time. "Now where are you *really* from?" At that point, a little tiny spark of compassion came back, and I said, "You're right, my parents are from Mexico, I'm Chicana," and I saw the sigh of relief. At that point, I don't think he was listening anymore.

But when people ask me, "Where are you from?" I'm beginning to ask myself internally, please tell me your story first. I want to know who you are. Because as we develop the sense of humanity, I think we need to do what Margaret Lawrence suggests, and that's to know our own inner workings before we ask others their story. Hear your own voice. Admire your own beauty. Reclaim your cultural beginnings.

REMEMBERING OUR STORIES

As a Chicana, I've been on a journey of remembering - remembering my stories, remembering my family's stories, and remembering my ancestors' stories. I smile as I drive alone sometimes. Sometimes I laugh out loud, by myself, because I'm remembering the stories. Recalling what it's meant to me to be Chicana, and to grow up in this country, looking darker than many of my friends. Having hair that didn't exactly lie flat. Trying to look white as a little girl, because as a little girl that's what was important to me.

When my name was changed at the age of five, from María Agapita Resendez Guajardo to Mary Guajardo, something changed in me, and my story began to accumulate. My brothers and sisters had their names changed by their teachers on the first day of school, from Angela to Angie, Cecelia to Sally, Martín became Martin, José became Joe, and Guadulupe became Lori. As we had our identities changed, our stories began to accumulate. Now, I continually ask in frustration, who gave our teachers permission to change our names? Who gave our teachers permission? My kindergarten teacher, who gave her permission to change my core, and to call me by a name that was foreign? Our stories begin at a very young age. It was not until later

when I was in my twenties that I reclaimed my name, and that I went from being Mary Guajardo to becoming María Guajardo again. It was a long journey! And how many of our children go through that journey, in lots of different ways? And that journey has many different facets, and some of them are funny. And that's why, when I drive sometimes, you'll see me laughing in my car, because I'll remember.

I remember being seven years old, and running home and saying, "Mamma, Mamma, Sabe Que?, Sabe Que?"and sharing with her that that afternoon, we had made waffles in my second grade class. As a Mexicana growing up in a Mexican family, we ate with tortillas. We ate rice and beans. We ate tacos and tamales on special occasions. We didn't eat with forks. We didn't eat salads. We were healthy, but our menu was different. And I remember running home that day. "Mamma, Mamma, Sabe Que? We had waffles today. We had white people's food!" I was just beside myself. And that's part of my journey. That's part of my story, and I need to remember my stories.

I remember being four years old, not in school yet, and my parents were migrant workers. At that age, we were too little to be left anywhere. My older brothers and sisters were in school, so my parents would take me and my younger sister with them. I remember this particular time because it was cold outside. They would start working about five in the morning and they would wrap us up in little blankets, and I was four and my sister was maybe two turning three, and we'd be left in the back seat of the car all bundled up, feeling safe in the back seat of the car, while my parents went to go pick olives. We were picking olives then, and I remember the olives. You can hear the sound of olives, because they fall into the metal containers that are hung around a person's neck. You can hear the olives falling on the tarp as they come down from the tree. I remember being little and being in the back seat of this car and waking up, and it was still too dark and too cold to go join my parents, and so I remember sitting there sort of bright-eyed and wondering, "Now what do I do?" I remember finding a crayon on the floor of the car. It was my magical crayon. I had found a crayon, and I didn't have anything to write on, but I had found a crayon. Pretty soon my little sister was awake and we had this crayon, and we didn't have any paper. So we looked around. (We were quite resourceful!) We looked around, and we started drawing on the roof of the car. I can't remember exactly what happened when my parents found out, but that's one of my stories, that's part of my beginning. I need to remember my stories.

I remember the influence that the Catholic church had on me growing up. It was an important factor in my life. It was so important, that I remember being very young and playing church. We would fight as to who could be the priest, because then we would play communion, and we would get a little pack of Life Savers and we would say, "In the name of the Father," and we'd give each other communion. I remember that story, it's part of my journey, it's part of growing up.

I remember the first time that I celebrated Thanksgiving. I remember discovering this holiday. My sister was in high school, and I was in elementary school. She came home and she started telling us about this holiday called Thanksgiving. How everybody bought a turkey, and so we needed to do Thanksgiving. I thought this was quite exciting. We had done little hand turkeys at school so I thought this was great. So my family, Mexicanos to the core, went and bought a turkey. Now we didn't have the full story yet. We weren't exactly sure how this was all supposed to be conducted, so we cut it up into little pieces and my mother made molé. That was my first Thanksgiving - the first one I remember.

ACCEPTING OURSELVES AND OUR REALITIES

Our stories are a part of us. It's a part of my beginning, and it's a part of who I am now. So as we think about healing ourselves, I think we have to respect our beginnings. We have to respect where we started, and we have to

stay away from the "lookie-loo" phenomenon until we've discovered our own stories and are willing to share them. I've shared some humorous stories, but not all of them were humorous. There was a lot of pain in growing up. There were a lot of messages that I didn't understand. There were a lot of things that I wanted to change, and a lot of things that I was embarrassed about.

I was embarrassed about being on welfare. Whenever we would stop working in the fields, we would go on AFDC. I was embarrassed that I didn't have white bread at home. I remember when I first got to college and ate in the dormitories, people thought I was crazy. I'd pile up the white bread. I thought it was the neatest thing. I just loved it, but I had never had it as a child, and that's part of my growing up.

As we begin to work on our journey, and as each one of us thinks about the process of healing, I'm reminded of the beginning of the word, and where the word "heal" comes from. It comes from the idea of being whole, of being complete. The word "heal" comes from the word "holy." I would ask you to think throughout the day, what will it take for you to heal, for you to become whole, for you to touch the core of your wholeness, that holiness, that sense of self that makes you who you are?

Often times though, I have to be reminded why I'm on this journey, and recent experiences in my work are great reminders. Last week, I had two young seventh graders run into our office. As the two little Chicanitas came into our office, I could sense something was wrong, and so I asked Paula and Ysenia, "What's going on?" Our office is in Baker neighborhood, Little Mexico in some people's vocabulary. They said, "We've been chased by some guys, some gang kids. They were chasing us in a car and we raced through the alley. They told our friends that if they caught up with us, they were going to kill us!" Seventh graders. Two tiny little scrawny-looking girls. Part of their everyday reality is being fearful for their lives, because those guys in the black car who flashed their guns at them have threatened to kill them.

I am reminded of our reality, and of our children's reality, by other stories. A family member came to me not very long ago, and said, "I need to share something with you because I haven't told anyone, and it's becoming harder to keep it a secret." She shared the story of how she was molested by her stepfather from the time she was in fourth grade until the time she was in ninth grade. I sat with her and held her while she cried, and I began to ask myself, how will her journey turn out - this journey of healing? Because it's about healing, not only ourselves, but our children. Our little sisters, our nieces, our cousins, they are all out there. It's about healing ourselves, and each other.

It's only by finding our collective voice that we will be able to provide and create a better future for our children. We need to find our voice. We need to discover our story. We need to hold each other when things get hard. We need to laugh by ourselves as we drive down the freeway, listening to our music. We need to remember our stories as we begin to uncover, tap and develop the sense of humanity. I asked myself early this morning, "What will it take?" What I came up with is, it's going to take so much energy. It's going to take courage, and it's going to take the will, the decision that something will change in our lifetime, today, next week, this year. It's going to take a lot of courage to oppose the neglect, the trauma, and the hatred that confront us everyday.

CHALLENGING THE SYSTEM

I pick up the newspapers daily in Denver, and I read about the anti-immigrant wave that is sweeping this country. The resolution to that anti-immigrant wave that is currently being proposed, is to kick them out of schools. Don't provide them health services. Don't let them speak their native language. I'll remind you all that Colorado is an English-only state, and that anti-immigrant wave will soon hit this state. It's here already legally, through legislation. It will soon hit this state. I would ask you to be a part of the

collective voice that says no. Our sense of humanity is too deep to allow this kind of hatred against each other to be perpetuated in our city, in our state, in our neighborhoods, and within our families. I would ask you to join me in being part of the collective voice that says that will not happen here. I think of my own story and I feel blessed 35 years old. I am young. I hope when I'm 50, I'm still saying I'm young, and I hope when I'm 80, I say whatever I want. I feel blessed that I was born 35 years ago because I am the daughter of Mexican immigrants. If I had been born a year ago as the daughter of those Mexican immigrants, and if Proposition 187 passes in California, I would not have received an education. If I had been born, not 35 years ago, but a year ago, and I would have gotten sick, I would not have received health care in this country. I would have forgotten my Spanish, having been punished at an early age for speaking it. And according to the latest book, recently published, I would have believed that I was genetically inferior, cognitively. That's what I would believe, because the latest book is telling us that, although it's not conclusive, it seems like there are genetic differences in terms of cognitive ability among people. Now, how much time has been spent looking at the intelligence measures that have come to that deduction?

As a psychologist, I tested children frequently, and one of my favorite questions was, "Who discovered America?" Now the correct answer, according to the test, is Christopher Columbus. You get two points for that answer. Well, I remember testing an eight-year-old, and I said to her in Spanish, "Mija, who discovered America?" She thought about it and said, "Bueno Maestra creo que fueron los Indios.....the Indians discovered America!" Well she didn't get two points for that answer, so I broke the testing norms a little bit and I said, "Mija, after the Indians, who discovered America?" She thought and she said, "Well Maestra, after the Indians....it was those Mexicanos. The Mexicans discovered America." She doesn't get two points for that either. So I asked her one more time, "Mija, after the Mexicanos," (because I thought, "She's on the right track here"), "after the Mexicanos, who discovered America?" She looked at me very thoughtfully, and she said, "Bueno Maestra, after the Mexicanos you couldn't discover it anymore." Unfortunately, she didn't get two points for that answer either. Now was that child genetically inferior? What can we say about the developers of this test? (From the audience: "They are genetically inferior.") I didn't say it, but thank you so much for the comment.

We need to challenge. We need to challenge the propositions that are being laid before us - that anti-immigration is good; that genetic inferiority exists; that being mono-lingual in English is the best way to go. We need to challenge the propositions that are being placed before us. We need to challenge those as part of the collective voice. We need to challenge those because it will be a part of my healing, and I hope it will be a part of your healing as well. To know that I am not being punished will also be a positive piece of your development. Because we can no longer stand by silently and let these propositions and these statements be voiced. Silence in this circumstance, and silence at this time, is neglect. It feeds the party that's proposing them. We can no longer afford to be silent. We need to bring our voices individually. We need to bring our voices collectively. You need to challenge the individuals who are supporting those statements. It's not enough to say, "I'm opposed to it." Help me. Help my children. Help your grandchildren. Don't let offensive, discriminatory comments be proposed any longer. It's going to hurt, it's going to take courage, and if you are white, people will call you names. If you're Latino, people will call you names. If you're Native American or Asian or African American. But you know what? People have been calling us names for a long time. Our collective voice, perhaps, can begin to turn this tide.

The tide is changing anyway. The demographics of this country are changing. Right now, 25 percent of this country are people of color. In the year 2040, 50 percent of this country will be of color. In the year 2040, one

out of every four people in this country will be Latino. The demographics of the city of Denver reflect what this country will look like in the year 2040. I felt it was magical when I discovered that statistic. Currently, Denver has a population of European Americans of about 57 percent. In the year 2040, the country's population of whites will be about 50 percent. Latinos in Denver make up 25 percent of this city's population. We will make up 25 percent of this country's population in your children's lifetime. African Americans constitute 13 percent of this city's population and they will constitute 13 percent of this country's population. Asian populations will increase to three percent, which is their makeup of the Denver community. They will constitute 10 percent of the national community in the year 2040. Native Americans will remain stable at about one or two percent. Currently, that's the population makeup in Denver, and that's what it will be in the United States in the year 2040. The demographics of this country are changing, and it behooves us to understand each other's stories. And if we listen to Margaret Lawrence, it behooves us to understand our own story first.

CONFRONTING THE VIOLENCE

Let me take a few minutes to close now on a particular issue that I would like to share thoughts on, the issue of violence. You may have seen recent articles in the paper. This one out of the Rocky Mountain News, where it reported the rate of violent crime is soaring. In this article, the Justice Department conducted a survey with 100,000 individuals interviewed for the first time. For the first time, a new category was added, and that was the category of sexual assault. We're looking today at women's health issues, we're looking at our own process of healing. We're looking at the violence that is detrimental to that healing and to that status of health, and it's only in 1994 that the Justice Department is beginning to share with us the data on sexual assaults. One-half million, as if it were insignificant. One-half a million! We need to form a collective voice to begin to stop this cycle of violence - that half-a-million sexual assaults occurred last year alone. It included completed rapes, attempted rapes, and non-rape sexual assaults. The study also concludes that crimes of violence continue to increase while the prison population also increases. Now I want you to put these pieces together for me, because I'm struggling to understand them. Crime increases, crimes of violence increase, assaults against women increase, our prison population increases. In fact, the prison population has doubled in the last ten years. I believe in incarcerating the perpetrators of violent crime, but I also believe that we need to put our energy and thought into prevention and intervention. We cannot lock up everybody in this country. A Latino child at the age of five right now has as much chance of going to college as he does of going to prison. My five-year-old godson has as much chance of going to college as he does of going to prison. If the stats continue as they are, 50 percent of all African-American males will be incarcerated at some point in their lifetime. We need to start rethinking how we do this business. We need to become more responsible about advocating for a new, more humanistic approach to how we're raising our children and how we're dealing with violence, how we're dealing with poverty, how we're dealing with racism in our country. In this article, a retired New York police lieutenant says, "What it should raise in the minds of citizens is whether the tough-on-crime strategy of increasing sentences and building more prisons has any affect on crime." My sense is that it doesn't. We need to begin to think about alternatives.

Another startling reality was sitting down last night with Denver's election guide. I wasn't going to read it, and then I was fascinated as I began to read it. One of the questions that was asked of all the political candidates, and I would encourage you, absolutely, to look to see what responses are to the question, "What more can be done to combat crime?" We see that the violence is soaring. We see that women are at the victim end of much of that violence, and yet some of our political candidates, in response to that question said, "Nothing more can be done." Another one responded, "I don't know." Well,

if you don't know, then maybe you shouldn't be running. Our children and our families and our neighborhoods deserve to have elected officials who have thought about these issues, elected officials who can provide leadership in our communities.

I would encourage each one of you, as part of this collective voice, to become informed. I wasn't going to read it, but I encourage you to read it. I was amazed. I was astonished. I was absolutely defeated by the end of it, reading some of the responses of the candidates. In 1994, it's difficult for me to believe that men who kill their wives are being told by judges that they had a good reason to get angry, and that murder, in fact, can be condoned. In 1994, men are killing their wives and it's okay, say our judges. I believe that this thinking must change, and that we as women must be strong voices across this country and condemn these actions and these thoughts. It is not okay to kill women. It is not okay to kill women for any reason, and certainly not in cold blood. We need to help each other raise our children so that they too can believe that it is not okay — not only to kill each other, but it is not okay for men to kill women in our society. We, as a collective voice, can begin to change that tide.

November 8 is next week. It is around the corner, and I encourage you to become part of the collective voice. Be informed. Not only should you go and vote, but take someone with you. Think of an 18-year-old, a 19-year-old, a 20-year-old, who hopefully is registered. Take your mother. Take your daughter. Take your god-daughter. Go with someone and become part of the collective voice. Some of the choices aren't great, but we need to start somewhere. Don't vote for anyone who says, "I haven't thought about crime, and I'm not sure what I would do." You deserve better leadership than that.

HEALING OURSELVES

Let me close with a couple of thoughts. Our individual journeys are powerful journeys. They're journeys full of pain. They're journeys full of love. They're journeys full of laughter. I would hope that as you drive alone, as you cook dinner, as you get up late, that sometimes you catch yourself laughing at some of those stories. Some of the stories need to be laughed at. If we don't laugh, we'll cry.

Some of the stories are just funny. I was five years old and I wanted to be white, and my little next-door neighbor, Vivian, was light complexioned. And so I asked her, "Vivian, how did you get so white?" Vivian said to me, "I take baths in milk." So I went home and tried it. I didn't know how I could keep getting enough milk. They would notice that it was missing. Then I thought, when I actually turn white, what will I tell my mom and dad?

Some of the stories are funny. Some of them are tinged with sadness, but we need to discover our own stories. Discover your voice. Discover your voice, and then speak it. Softly. Loudly. Share it with your mother. Share it with your daughter. We need to start with each other.

Another friend, although I've never met her, is Nikki Giovanni. I was reading Nikki's work, and in one of her writings, she shared some thoughts that I'd like to share with you now. She says, "We plant, we reap, we try, because we are human. We hope, we continue. Our soul is rested, but it will have to get up in the morning and start again." Rest your soul today, rest it tomorrow. When you get back to work on Monday, start again, and remember that you're not alone. Remember that your journey is one of the most precious stories that you can share with someone else. Gracias!

Panel Presentations

Panel Presentation

The Dimensions of Mental Health

Ruth L. Fuller, M.D., F.A.P.A.
School of Medicine, University of Colorado Health Sciences Center

The panelists have just asked me to speak on the areas under consideration from personal points of view. I would like to begin with a bit of my background.

I grew up in New York City but spent most summers in Washington, D.C. My mother would ship me off to my cousins' homes at the end of June, and I would return around Labor Day. In adolescence, I attended college in Washington, D.C. By invitation, I relocated to Denver in 1978. Since I have lived in different settings, I feel that these experiences make me a multicultural person.

In answer to the question, "What have been my struggles my career?" My career includes being a physician, psychiatrist, child and adolescent psychiatrist, and psychoanalyst. Mainly, I think that I have struggled with forces that most women of color encounter. For example, to date, I am still the only physician in my extended family. However, we do have a crop of educators, lawyers, mathematicians and computer experts.

With my introduction into medical school, I was presented with the fact that my colleagues and I struggled with some very basic differences. First, there were less than five persons of color in my immediate class, and less than 10 in all approximately 600 students. The time was 1957 and the country wrestled with the question of whether or not each "(citizen) is created equal". For day to day living and working, the answer was no. In order to make some order out of the emotional disorder that I was encountering, I began a quest for a way of understanding the diverse humanity that surrounded me. I looked for a frame of reference. I still use this approach in teaching undergraduate, graduate and postgraduate students and colleagues. The subject relates to changing populations. The question is how to deliver culturally relevant mental health services to any population in any setting.

A few years ago, there was a drawing of a Black baby in a cradle in a treetop. It referred to the "Black healthcare: A Crisis in Need of a Cure." I think that the crisis in need of a cure is "number one" on most people's "Hit Parades," unless they have had a need for mental health care. I was reminiscing and talking about sitting on the ColoradoCare Benefits Committee for a year. I found with meetings as frequent as every two weeks, there was still the mental health 'issue'. The issue was whether or not mental health care was relevant, necessary or going to cause the demise of all health care by being too expensive and not cost effective. Part of my discussion was similar to what I would say in a classroom, seminar or committee. An individual who wishes to understand people and their needs must have a conceptual framework for trying to understand both her/his own cultural background, and then any other cultural background.

One such framework is for an *ethnosystem*. This framework was published in 1984 by the Howard University Press, it happens to be for Black families. In the same book, one finds other frameworks presented in terms of Asian/Pacific-Americans, for example. This type of organizer aids in having an individual understand any one person in any one family. Some of the issues are geographic (physically where one is located in the world) and economic. About a year and a half ago, I looked up the economic status of women and children in the United States and it was getting worse. It is not comfortable to think about such a large portion of the population of this country getting poorer. You have younger poor; you have young families that are poor

and single moms that are poor. With some exceptions the one group that seems to be less poor than 20 years ago is the older American.

There are a number of factors that influence one's mental health and they are noted across cultures. As I was looking at some of these important factors, a thread emerged. Relationships are very important to all ethnically diverse groups. Non-ethnically diverse groups may have important relationships but I was looking for the thread. We speak of the need for support groups. The first support group is the most immediate family. For people of color, the family is defined differently; it is much more inclusive. I think of my own experience - the cousins that I visited every summer in the heat of Washington, D.C. For years, I did not realize that they were not my siblings because we were cared for collectively. Other factors include divorce and aging. Multigenerational living is more of a norm. From my own experience, at one point, my mother decided that, due to her loss of vision and other illnesses, she no longer wanted to maintain the apartment that we had shared in the housing project. She came to live with me, my husband, and then kids, in a brownstone in Harlem. It never crossed my mind that she would not do that. I have given consultation on multigenerational living to non-minority colleagues who have gone to get their older parents and have been told such things as, "Oh, you're doing this because you have not resolved your dependency issues."

There are also issues around education. In Denver in recent months, there has been more focus on the school dropout rate again and particularly in high school. But I find it very discouraging that there are still issues of discrimination. A woman of color may have similar or equal credentials, but not necessarily make as much money.

Another conceptual framework adds another dimension. I borrow this from one of my Latina colleagues who pointed out that it is also helpful to consider where any one person falls on the spectrum of traditional to contemporary, traditional for the person's culture and contemporary in a more blended culture. People can take a different view of different aspects of their lives as being more traditional or more contemporary. For example, I am very traditional about time. I don't mind if somebody shows up three days, four hours and twenty minutes late for an appointment. My first greeting is, "I'm glad you could make it. Did you have difficulty?" Usually, the individual tells me about the tasks that they had to take care of before they could come in and lollygag with me for about an hour.

We may ask the question, "Why are we doing this (struggling to reach understanding)?" When we look to the future, the future of young women, there will be more ethnic and cultural blending. In December 1993, Time Magazine did a special issue in this subject.

With those thoughts, I will now try to quickly mention some of the issues that I think are pertinent to mental health. As a separate entity, mental health is not a part of many cultures because the cultures have not separated mental health from physical health or from overall well-being. The phenomenon of separating physical and mental health from overall well-being is part of western European-American medicine. Some medical terms only came into being some 100 to 130 years ago, some originating in central Europe.

What then, is the task of those who offer skill in knowing about mental illness? First, when talking about ethnic diversity, women, children and adolescents, you cover groups of chronically underserved populations. Second, chronically underserved populations are usually the first to be eliminated from the hard-pressed budgets of public institutions. The University of Colorado is a public institution, but am thinking of an even more public institution. For 12 years, I worked as a staff psychiatrist and director of a clinic in a housing project in East Harlem, New York. The families using the clinic impressed years of staff members and students-in-training with some basic principles: one - be in the neighborhood, not far away; two - do not create an obstacle course between the families

and the staff; three - stay with the clinic long enough to establish some credibility; four - make difference in language a mutual struggle, not just the family's struggle; and five - if you work with these issues, people will come.

Recently in October, there was Mental Illness Awareness Week. Major depression was a major focus of this campaign for public awareness. For women throughout their lifetimes, the estimated incidence of depression is 10 percent. When substance abuse is added, the incidence is closer to 30 percent. The incidence is expensive. Costs are estimated at up to $43 billion for depression and $174 billion for overall mental illness. Let us think about what we know: you don't feel well when you are depressed; you don't work well when you don't feel well. In meeting ethnically diverse women, it is the task of the practitioner of Western medicine to figure out how to translate what s/he has to offer, and not the family's. If families are asked to do this work, they tend to leave. At the same time, people come in because there is something wrong, and they would like some help that is not available among their traditional resources. As one Native-American mother said, "I know my resources, that's why I'm bringing him here. This is more than is in keeping with our culture." A different example of the struggle to understand and to make myself understood is seen in the comment made to me by a number of Hispanic mothers. "I will speak English because your Spanish is so bad, I can not understand a word that you're saying." I had tried, so each of the mothers tried. By the way, each was quite right. Her English was much, much better than my Spanish!

As professionals, there are other stressors. As a woman of color, your net worth is less than your Anglo counterpart. For example, I have been seated on committees that have decided to add an assessment of two - five hundred dollars for being there. When that happens, I look at the other committee members and know that they have no concept of what such an assessment means to me. My presence on a committee says, "You're like me."

During the break, we were talking a little bit about some issues of privilege. Those individuals that have the privilege of class, color and religion have a very, very different daily life than do women of color who deal with one or more of these 'eliteisms'.

Some other basic misunderstandings that occur in terms of mental health include: misunderstandings that occur in terms of what family roles are, how people treat each other, and the values associated with certain concepts. From my own background, I often use the place and perception of aggression. My tolerance for aggression is higher than some of my colleagues. When families speak more spontaneously, they often have a different understanding of what is being conveyed, especially in relationship to children. An example would be the saying that Bill Cosby made famous, "I brought you into this world, and I will take you out." More than one parent has been seen as very likely at risk for child abuse.

There are other communication issues besides translating from one language to another. I translate from English to English. More than one African-American woman has been on their way to the State Hospital because she described her husband as 'evil'. When the interviewer said, "Do you believe he's possessed by the devil?", the patient replied, "Only in the morning, because he is real evil in the morning." This statement became the documentation of why this woman needed to be in a long-term psychiatric hospital. I happened to be present and I did intervene.

There are other aspects of misunderstandings. There are stereotypes that we all hold because we are not particularly familiar with a lot of other people in different places. We are also influenced by a tradition of the visual arts, which are very powerful. I still think I wanted to come west because of John Wayne movies. I was looking at the surroundings shown in the films, and it took a while to dawn on me that something was wrong with the picture. Another factor for moving west was that someone was going to bring me out, pay for the move and make me full-time

faculty. I did not become full-time faculty for 12 years after training because I thought that people in academic medicine were in a different world concerning real life (I would have guessed somewhere around Pluto. Now, I think that the have moved up a little to somewhere around Jupiter).

Now, there is enormous impetus now in terms of diversity. I use the word diversity because that's what we've been teaching. I've borrowed something from Linda Chase, Equal Opportunity Specialist for the University of Colorado Health Sciences Center. She has a training series called "Death of Affirmative Action — Birth of Diversity." The concept of diversity seems to be much more inclusive or a horizontal organization, like a spoked wheel. The assumption is that each person has her/his individual expertise. The expertise is based on the fact that no one else is living life for them. It is a joint effort trying to match what we (service providers) have to offer with what a family needs.

I'd like to spend just a couple of minutes on some of the changes that have taken place just in my career in medicine. One of the growing areas of thoughtful research is in special centers for mental health throughout the country, we have one right here in Colorado. The National Center for Native American and Alaskan Native Mental Health Research is located in the Department of Psychiatry. I would strongly recommend becoming familiar with the center and it's journal. In California, there is a center for Ethnopsychopharmacology. The work includes the study of the effects of the metabolism of medication as they vary from culture to culture. You may have heard reports from families about the effects of medication or other substances that made them unhappy, for example, the metabolism of alcohol. It has been found that different ethnic groups do not metabolize alcohol well. They are much more susceptible to side effects and toxicity. One group is Native-Americans. Other groups reported include some Asian and Eastern European groups. My own experience has come from working with parents of various backgrounds who had very low tolerance for e.g. lithium.

Panel Presentation

The Dimensions of Substance Abuse

Geri Reyna-Challis (Taos Pueblo)
Eagle Lodge, Inc.

(Note: The following presentation was printed from a direct transcript of the proceedings and has not been edited by the presenter.)

How many of you are clinicians and therapists working in the area of substance abuse? How many of you are working with Native-Americans? I just finished a conference presentation focusing on working with Native-American clients. Our clinic is working with a number of patients who have dual diagnoses. We are collaborating with the University of Colorado Department of Psychiatry with Dr. Shore. Our patients come from Southern Arizona, New Mexico, Montana and the North Dakota/Northern Plains region. We are one of the few organizations that I know of that will be dealing with dual diagnoses. My specialty is working with women. Five years ago, I developed a substance abuse treatment program for Native-American women. (I specialize in this area for some very personal reasons.) I am involved in my own personal recovery and that helps me to understand the women that I work with. A woman who seeks treatment is a stigmatized woman, especially if she is a woman of color. Although I work mostly with American-Indian women, my doors are always open for consultation on an outpatient basis for women of all races and ethnicity. Many barriers exist for women who wish to get into treatment. In the early '80s, women who had substance abuse problems were pretty much stashed in the closet. I should know. I was one of them. One of the things that we realize is that we get tired of being tired. We run scared. We run blind. We feel helpless. We are afraid of what others will say. In our recovery, we say that addictions - whether it's drugs or alcohol - cause our lives to be unmanageable in all areas. We lose people, places and things. Some of the women do sacrifice themselves to get help, even if they have to lose people, places and things. When women come into our program, whether it's residential or outpatient, the strongest emotion they display is fear. It takes a while for them to be able to say, "I need help." A lot of our clients come into treatment programs through the judicial court system. In the long run, they begin to realize why they're there. At first, they retaliate. But after a while, they are glad that somebody cared and made them go into programs. There are many fears: the fear of losing our children, the fear of losing a home, the fear of being without friends. A lot of my patients are from the court systems. They lose their children because of their drinking or leave their children unattended to go out and drink. Many of them take care of themselves in the sense that they do whatever they have to do to cover up their feelings or hide their addictions. The first step is to realize that problems exist but that they can do something about them.

In my outpatient program, we hold women's support groups. Most women do not realize that they have a lot to offer other women and other addicts. In our groups, we learn who we are, what we are, and where we come from. One of the things in my circle that I ask is, "How many of you know where you came from? How many of you know your language, your history of your tribe, and the history of your family?" You'd be amazed how few can answer those questions. They don't know where they come from. A lot of times when they drink, they cry a lot, because they can hide themselves and their identities. Every woman has an identity. But they learn to hide in the closet. They're so sensitive

sometimes that if anybody says anything to them, they react. In our program, we teach them to love themselves. Look around you, look at the beautiful women, the sisters, the way they dress, the way they fix themselves up. Think today of the women out there on the streets, in homes, in offices, wherever they may be, that are hurting very much. It could be your mother. It could be your sister. It could be your grandmother. It could be your aunt, or a friend - a close friend, who is struggling with a problem of addiction. They do not know how to receive themselves or acknowledge themselves. And that's what we do. We work with recovery issues, and we also work with identification. You're okay even if you have a problem, so let's get to work. We do a lot of self identification (looking into the mirror) which requires a lot of Kleenex. For the first time, these women identify and acknowledge themselves. They get in touch with themselves, and they get mad at themselves.

During this journey, we ask the women to write about who they are, what's going on in their lives, what they are feeling, and to see and process that. We are very sensitive to the woman who cries because we can feel it. You can laugh and you can cry, but in order to be able to help these women in programs, you need to be able to be very sensitive, and offer nourishment, caring, empathy, and most of all, for support. This summer, we are going to kick off a women's empowerment support group, go through quests, go up in the mountains, have talking circles, get in touch with nature, and holler.

A word about hollering: It is a way to clear the air, to get everything out of yourself. It's okay to do that. I would like to ask those of you who believe in yourselves to stand up and clap your hands, acknowledge yourselves. More power to you women and our few men in here, to stand up and clap your hands. Acknowledge yourselves, give recognition to yourselves that you're here today! How many women are going to do that? Look around, look around at the women who are clapping. Look at the smiling faces.

There are a lot of women out there who don't acknowledge themselves. They don't know how to begin. Each and every day, you wake up, you look into the mirror, look at yourself and say, "Damn I look good. I feel good." In our talking circles, we learn to celebrate being Native-American women, to thank our creator for this day - whether it be rough or sad or powerful.

It feels good to see my patients come through treatment and say, "I made it." That's why in our groups, we stand up and acknowledge ourselves beside the mirror and clap to each other. We look at each other and say "You're not as bad as people think," or "You're not as crazy as you think." You just need someone to be there for you and help you. That's what sisterhood is all about. It's about loving one another.

Yesterday, I was lost here trying to register, and somebody helped me to that registration table and said, "Thank you." It feels good to know that a woman from another race can come to me and say, "Are you lost?" I said, "Am I that obvious?" So it feels good to acknowledge one another.

Substance abuse is a very chronic condition of critical importance. It's moving out of the closets and coming out of the dark rooms, especially for the women. It's been okay for a man to go out and live it up and do what he wants to do. But the wives, sisters and girlfriends had hidden substance abuse problems that were never acknowledged. The women would sedate themselves with alcohol - a nip or two here and there - and slowly it became worse and uncontrollable. Today I am pleased to say that there are a lot of women that are coming out of the closets and saying, "I need help. I think I have a problem," or "I don't really have a problem, but could you help me anyway?"

A lot of times I challenge the women in courts, especially the moms who are charged with child abuse or child neglect because of their drinking. I love doing some reality hot seating, because it's very important for them that, if they can't acknowledge their problem,

they know someone is seeing it. My golden rule is, "don't 'BS' another 'BS-er'" because I've been there, and I've probably used some of those excuses myself. All of our therapists and counselors go through intensive training. The majority are recovering. It helps. We do interventions. We do preventions. We do treatments. We're "Jills-of-all-trades." We are there for the women. We are there for the children. We are also there for the males.

Last week I was at a meeting and this lady that I had gone through the program with came into the meeting. She was celebrating her one year birthday, and her husband was there. When she was speaking, she told her husband, "You can't tell me anymore that I can't do anything. I have finally awakened. I am a flower that I believe to have grown and bloomed every year." I tell my women, "Pick a flower - not just a rose, but pick a flower that resembles you." I love a cactus flower, because I can sting back. Now I can stand up and I can prick anybody I want. There is help for women addicts. There are more agencies serving women than ever before in our lifetime here in Denver. If you are a clinician, volunteer your time. You'll never regret it.

Panel Presentation

The Dimensions of Violence

Abby Trujillo Maestas
Salt Lake Rape Crisis Center

Every time I hear about the "Courageous Woman of Action Award" I received, I picture myself looking a lot like Pancho Villa - you know, with bullets and pistols. But that's not really the kind of courage we're talking about. The kind of courage being talked about is what we're doing here today - taking an opportunity and a chance to get to know ourselves and share the stories that we have. We've heard a lot about our personal stories and our histories and where we are from and who we are. One of the issues that we have as women of color is that we cannot fight for our cause until we know who we are. We cannot. It's not possible.

I want to publicly thank Maria for broaching the subject of violence this morning. We have, as women, and particularly as women of color, pretended that violence does not occur in our lives on a daily basis. Every female that is born in this country is born with the understanding that she will be, at some time, subject to a violent act. She will be raped. She will be abused. She will be molested. Every female. Men are not raised that way. Women are raised in fear. The most personal, dehumanizing, unbelievable, heinous crime is that of sexual assault. It reaches into the core and deepest part of our humanity and who we are.

The statistics tell us that one in five American women are sexually assaulted in this country. If you look around in this group, because we are predominately women of color, that statistic will be more like one in two. Half of us have suffered some type of sexual assault and sexual abuse and sexual violence.

At the Salt Lake Rape Crisis Center, I talk with women (and men and children - but primarily women) every day about this horrendous and heinous crime and injustice. I am amazed at how many women of color I see. I'm amazed at how many of those women hang their heads and say, "But it's part of our culture." It breaks my heart just a little bit because, as a Chicano, it is not and I will not let it be again, part of my culture.

If we want to put violence and rape and sexual assault in a category, I think it is important that we address the issue of domestic violence, but that we not put it in an area that we call domestic violence so that it sounds pretty. Those are good words. They had impact in the beginning. They no longer have the impact. Domestic violence is violence that occurs where we live. What we must understand as women, particularly women of color, is that we live in this world. So if we talk about domestic violence, we talk about all violence to all women everywhere, and not just in our homes. We are told that one out of four females in this country will be sexually assaulted, sexually abused or sexually molested before she reaches the age of 18 - 25 percent of the female population! If it were politically correct and appropriate to ask the women in this room to stand if they had experienced sexual assault in their lives, we would be amazed, because most of us would have to stand. Most of us don't talk about it. Of that 25 percent, one out of two would experience a rape a second time in her adult life.

The oldest woman that I have served at my center in Salt Lake City was a 96-year-old woman who was in a wheelchair. The youngest was a three-and-one-half-week-old male infant who had been sexually assaulted to such a degree that he needed surgical intervention, emergency surgical intervention, to save his life. Sexual assault and violence are

part of a culture, but it's not part of the Hispanic culture, it's not part of the Native American culture, it's not part of the Asian culture. It is a part of the female-male culture.

Ninety-eight percent of rapes are committed by men. Now keep in mind that only one out of ten rapes are reported by women. I'm talking about rapes, I'm not talking about sexual assaults. I'm not talking about children under age 14. I'm not talking about men. I'm talking about forcible rapes reported. Ninety-eight percent are committed by men, and 80 percent of those are committed by the men that we know, the men that we trust, the men that we nurture, the men that we have taught as our sons to have the privileges that we will never have. We must think about this as women, and as women of color particularly.

About 18 months ago, I sat in a hospital with a five-year-old girl whose head was the size of a watermelon because she had been sexually assaulted. Her assailants had smashed her head against a concrete floor, over and over and over again as they took turns raping her. Penal rape, object rape. Her assailants were her ten-year-old brother and her twelve-year-old half brother. The child suffered permanent brain damage. Where do we teach our children that this is acceptable behavior? Part of it is because we don't tell the personal stories that we heard about last night. Part of it is that we think that it is our lot in life.

I went to a conference where a woman got up and talked about how to stop rape. The woman said, "You know, I have finally figured out how to stop rape. You get in your car. You drive down the busiest street in town, and as you approach a group of people, you roll down the window and you say, 'So stop it.'" That's the only way we can do it because with all the studies that say it happens because men are depressed or men are feeling angry, the bottom line is, " Why do we climb Mt. Everest?" Exactly. Because it's there.

Who are the people that are sexually assaulted in this country? The majority of the people are the most vulnerable. Rape and sexual assault are crimes of violence. It has nothing to do with sex. We must understand that. We must believe it. We do not invite violence in our lives. We do not deserve violence in our lives, and we should not endure the violence in our lives. When a person — a woman particularly, because that's what we're talking about here today — has become a victim of violence, sexual assault or rape, she suffers in the areas that are represented along this table. She suffers in the area of mental health — Post Traumatic Stress Disorder, depression, suicide, neglect, and those are the basic ones. We are not talking about the women who shave off their hair, and my client who came in with her arms burned because she could no longer stand who she was. If he could do this to her, she must do it to herself, and with a curling iron burned herself up her arms and her legs over a sexual assault.

Victims of sexual assault suffer substance abuse. Do we not? Alcoholism, drug abuse and other types of substance addiction to stop the pain, to stop the guilt. We have bought the guilt so well in the country that we honestly believe it ourselves. When women come into my office, the first thing they say is, "I shouldn't have been there. I shouldn't have been wearing those shoes. I should have fought harder. I should have screamed harder." I had one woman say, "I shouldn't have been naked," and I had to say, "It is okay to be naked in your own shower. It is okay."

Victims of violence, rape and sexual assault are subject to chronic diseases. Let's talk about AIDS, and other STDs that last a lifetime and are passed on to children. Victims of rape and sexual assault are subject to the issues of reproductive health. I'm talking about abortion. I'm talking about raising a child that is the result of a rape, for 21 years — looking at that child every day — remembering! And it happens because women of color, in particular, have fewer resources, less access to the health systems that we are talking about here today. Of all the abortions in this country, about 72 percent of the women who receive them are white. We

know that the majority of people who are raped or sexually assaulted in terms of percentages are women of color. This is what we have to think about. That's what we have to know. We have to know that in this country, we're told that one out of five women are raped, and of that one out of five — out of that 20 percent — one out of every three African-American women in this country are raped. That's the way it is across the board for women of color, because of lack of access. So when we talk about health issues, we have no choice but to talk about violence. Are you scared yet? Yeah. I have been all my life.

We also need to talk about the cost of rape and sexual assault. Did you know that in this country last year, the cost of sexual assault ran about $63 million? That's just in the health system. Wow, that's a lot of money. But you know what? It's less than two months of the cost of the new Denver airport being closed. Think about it in those terms, two months. I honestly wish that I could get one day's revenue at Disneyland. For one day, I could probably keep the doors of the Salt Lake Rape Crisis center open for two years without worry!

It is important that we confront the systems we live with. We must demand bilingual services, services that are culturally sensitive. We must not be ashamed. I need to say this, it's important. We must be able to say, "Yes, I was a victim and I will not be victimized again - not by the health system, not by the legal system, and not by your system, your system that I am forced to live in as a woman of color." It is important for us to do that.

Panel Presentation

The Dimensions of Chronic Disease

Silvia Guillermino Corral, M.D., M.P.H.
Wasatch Homeless Project, Salt Lake Community Health Centers

I wanted to start by saying, "I'm really happy to be here," but actually I'm feeling sadness at the news I bring to you. As a family physician, I look at the whole person. I'm going to talk to you about chronic illnesses. Remember, however, that the problems of chronic illness are overlaid by issues of mental health, substance abuse and violence. In Salt Lake City, 26 percent of our homeless women are women of color. Our minority women are underserved, lack access, and have multiple problems and issues. As women of color, in our work and in our daily lives, we are wounded daily by injustice, by struggles and by misunderstandings experienced by our patients. It is very hard to be a primary care provider. We see these illnesses happening to someone who could be our mother, our sister, our brother; and we do not have resources to deal with it.

As I present this brief overview of chronic illnesses, I ask that we unite to heal ourselves first and become models to our communities.

CANCER: Chronic illnesses have a lot of different effects on people. This is cancer. When we're talking about cancer, this is an illness that's going to affect many of us. Lung cancer is particularly insidious. It is a major killer of women of color, affecting us more than breast or cervical cancer. We need to quit smoking and to focus prevention efforts on the young woman. Smoking behaviors are increasing in our Black and Hispanic women.

BREAST CANCER: It is now killing one of every four Hispanic women and is increasing in Black and Native American women. We started a comprehensive women's mammogram program. Since September, I have seen 80 women and diagnosed four breast cancers. One was Black, two were Hispanic, and one was White.

MAMMOGRAMS: Promoting mammography is essential. Women do not avoid mammograms because they don't want them. Cost, fear of pain and access to services (transportation, language, education) are real barriers to eliminate.

CERVICAL CANCER: This condition is easily diagnosed through annual Pap smears, follow-up exams, colposcopy and biopsies. Our barriers involve access, not our diagnostic tools. People have pointed to cultural taboos and issues, but in my dealings as a bilingual, bicultural, sensitive care provider, I do not encounter those barriers. I can get a 90-year-old Native-American to agree to a pelvic exam. I can get a 60-year-old Black woman to get a Pap exam. It is not culture. It is the ineffective cultural competency skills of many providers.

CARDIOVASCULAR DISEASES: Cardiovascular diseases are killing minority populations, not just in the United States, but worldwide. This is a phenomenon of a developed world. It has to do with exercise, obesity, hypertension, cholesterol and diets. We need to reduce our dietary fat to less than 30 percent of total calories. Teaching cardiovascular risk reduction behaviors is our challenge.

DIABETES: Diabetes severely affects all women of color. Thirty to 60 percent of all Native-American women, 30 percent of Hispanic women, and 25-40 percent of African-American women are affected by diabetes. This is probably not a random event. Genetic and familial factors may predispose our communities to diabetes. We have to own this fact. We have to engage our communities in overcoming the denial about this disease.

We must also lobby for appropriate research

into those diseases that affect us. New clinical trials have focused on Type I diabetes. That's the type which is usually diagnosed early and requires insulin. That's not the kind of diabetes affecting most minorities. A panel of experts was convened, and they decided, without doing any research that the treatment guidelines should be the same for Type II as for Type I. End of statement — no further research. I've talked to these experts, and they feel really quite comfortable with that position, and nobody is challenging the decision and the resultant medical model. These researchers haven't seen the aerobic exercise programs on the Zuni Pueblo, which were able to reduce the incidence of diabetes in that community. They're not familiar with Hawaii, which is reducing their level of diabetes with a traditional diet. They're not familiar with the success of community models, and yet all of the future health care providers from September 1994 on are going to be trained that one of the most important intervention when they diagnose diabetes is to give insulin. If you're a woman of color, you have a 40-60 percent chance of getting diabetes. Based on culturally insensitive research, you may be told to put a needle in your arm three or four times a day, because that is where research has taken us, and they have not pursued the question or alternatives.

DIABETES AND OBESITY: We're getting fatter, and as we get fatter, we get more diabetes. Why do we get fatter? Nobody really knows. Do we have some genetic predispositions to weight gain? Do dietary calorie restrictions help us lose weight? I have more questions than answers.

ARTHRITIS: The elderly Navajo woman in the slide has rheumatoid arthritis. She can't walk. People with lupus also get crippling arthritis. Yet very little research is being conducted in our communities about these illnesses. Very few prevention programs are being done, yet this is a very crippling condition affecting women's abilities to contribute to their families and communities.

I have described conditions which caused most of the deaths in our communities during the decade of 1980. Now we must add to cancer, heart disease, stroke, and other debilitating conditions, the newest disease—AIDS. If you look at women age 25 to 42, AIDS is the major killer. Hepatitis and other diseases that are transmitted sexually are now becoming chronic illnesses in our communities. We're starting to see more pulmonary diseases in minority women, more asthma in our children. I believe that within the next ten years, these are going to be added to the major causes of death in our communities because we don't have effective strategies to prevent them.

I have a few messages that I didn't have two years ago. One is, nothing's changed. We have more illness burden. We receive treatment later. The treatment provided is less technically advanced because resources are limited. Medicine knows how to detect, treat and prevent complications, but this knowledge does not translate to better health outcomes for minority women. We're not currently benefiting from the advances that are being made in our society. The illnesses which I see on a daily basis are a real burden to our community. Consider: you live in a neighborhood in which 50 percent of the people in that neighborhood are chronically ill. They have more premature deaths. Families are left without mothers and fathers, or sometimes without an extended family. We lose work productivity and economic nobility. People stop working because they get one of these illnesses. Chronic disease consumes a family's very limited resources. If you are poor or near poverty get one of these illness, what happens to your resources? Money and time are devoted to medications, to doctors visits, to ER visits. Financial and human resources are drained. Lifestyles must change: medications, diet changes, visits to doctors and others compete with family priorities. I see little family support, frequently because of family denial of the issues raised by chronic disease. We all know our grandmother got "it", and there is fear for ourselves and our children. Women frequently have to choose between taking care of themselves, or taking care of others, or changing

the traditional and cultural roles.

How can we support our communities and ourselves? We must embrace the vision of all women assured of an education, growing up with self-esteem intact, and strong spiritual lives. I ask as a health care provider that from this day forth, until the day that you die, that you do something to keep yourself well. Take care of yourself! These chronic illnesses are not differentiating between health professionals or patients. We are all minority women. We must model changing diets, roles, lifestyles and prioritizing prevention to our communities because we value health.

As health professionals, we must guide interpretation of poverty in this country. Our poverty is stigmatized. One may be financially poor, but not spiritually, physically, and emotionally poor.

We have to build coalitions for prevention and education. In Utah, I go to so many meetings where I'm the only ethnic person. I want all of us to be part of those coalitions, to learn to work with the American Diabetes Association, the American Heart Association, the Arthritis Association, the state and public health department. If we're not there, they're not going to know that we have the right to resources, and how to make them available to us. I really dislike hearing people say that "no minority women come to our programs." The hospitals put on all these diabetes education programs, but no women of color ever come. I say to them, "You're at the wrong place, the wrong time, with the wrong message."

If you have health care providers, clinics, or hospitals in your communities who are sensitive, who are non-judgmental, who are bilingual and bicultural, and who don't label the patient who doesn't follow through, who isn't getting better, as a "bad" patient, keep them, nurture them, and love them. Our communities often get abandoned by sensitive providers because it's hard to stay. There are so few of us. We've got to love each other, and our communities need to learn how to start loving us, too. Too often, the provider is seen as different, because we want to model, because we want to mentor, because we know that we need to be doing things a different way, for our children, and for our future. Our challenge is to remain and integrate our knowledge into the community unconscious. These chronic illnesses are here to stay. Denial is not acceptable. As women of color, together, we can change the outcomes.

Panel Presentation

The Dimensions of Reproductive Health

Estella C. Parrott, M.D., M.P.H.
Office of Device Evaluation, U.S. Food and Drug Administration

I am pleased to participate in the "Women of Color Working Together Conference" and I want to thank the Office on Women's Health and the Office of Minority Health in Region VIII for inviting me to speak today. I will discuss two areas — prenatal care and HIV status, and the impact both of these issues have on the reproductive health of women of color.

Let me just start by saying that there have been rapid improvements in medical science and in the systems designed to provide essential health care, but we know they have not benefited all racial and ethnic groups equally. We would all agree that the health care community has much to learn about how race, ethnicity, access and treatment patterns influence health status. We know that disparities in the health status of women of color remain widespread. Women in general, and women of color in particular, face major barriers to adequate care.

PRENATAL CARE

We are going to start with prenatal care. Access to maternity care has become a major public policy concern. In 1989, the United States' infant mortality rate ranked 19th among 33 industrialized countries. Infant mortality and its major contributing factor — low birth weight — are strongly associated with time of entry into, and continued use of, prenatal care. The importance of prenatal care has been well documented. We know it's important because it allows for timely intervention. A number of studies have demonstrated a relationship between the use of prenatal care services and birth outcomes. Adequate utilization of prenatal care has been associated with improved birth rates and lower risk of pre-term delivery. This is especially true for women who initiate prenatal care in the first trimester, or the first three months of pregnancy. Inadequate prenatal care has been associated with an increased risk of delivering a low birth rate infant, a premature infant, as well as increasing the incidence of infant and maternal mortality. In the early 1900s, about one in 150 women died from causes related to pregnancy. Factors that contributed to the downward trend in maternal mortality included such things as the introduction of antibiotics, increased use of blood transfusions to treat hemorrhage, general improvement in social and economic conditions, and most importantly, the addition of prenatal care.

Maternal deaths have been on the decline in recent decades. The leading causes of maternal death are toxemia, now referred to as pregnancy-induced hypertension; hemorrhage; blood clots; and ectopic or tubal pregnancy. In 1989, 320 maternal deaths were reported among 3.8 million live births in the United States. That's approximately eight deaths per 100,000 live births.

Although the reduction in maternal mortality has been remarkable, the latest available data show that women of color are still more likely than white women to die of pregnancy-related causes, and the risk for black women is the highest of all racial groups. Older women — 35 and older — are at highest risk for maternal death. When you look across all the age groups, you can see that for black women, the rate is increased at all age levels. It is important to keep in mind that minority women have made impressive gains in initiating early prenatal care or prenatal care in the first trimester in the past 15 to 20 years, but problems still remain. Surveys indicate that barriers to early prenatal care include

such things as high cost, lack of maternity care providers, inadequate transportation, and child care services. Demographic factors associated with inadequate prenatal care are such things as low income, less education, increased numbers of children, being unmarried, and living in inner-city or rural areas.

The two primary measures of prenatal care utilization are month of entry into prenatal care and the number of prenatal visits. Interestingly, since 1979, the percentage of mothers beginning care in the first trimester has remained stable at approximately 76 percent. It's still 76 percent today. Studies indicate that the time during gestation when care is sought, and the number of prenatal care visits varied according to the mother's racial and ethnic group and educational attainment.

In 1988, only 58 percent of American-Indian and Alaskan-Native mothers received early prenatal care. Similarly, 61 percent of black mothers received early care. There is considerable variability in the reproductive patterns of the ethnic subgroups that make up the Hispanic population. Among Hispanic subgroups, 57 percent of Mexican-American and 63 percent of Puerto Rican mothers initiated prenatal care early. This is compared to 83 percent of Cuban-American women. The proportion of mothers with early prenatal care was much higher among Japanese mothers, followed by mothers who were Chinese and Filipino.

Observe the third line from the bottom on this slide - it reads "Women who had late or no prenatal care." Black women were more than twice as likely as White women to receive little or no care. The last two columns demonstrate that for Black women it was 12 percent, and for White women 3.7 percent. Cuban-American mothers have the lowest percentage who entered prenatal care late, at four percent. This is compared to Mexican-American women who had the highest percentage, at 14.6 percent. They entered prenatal care late or had no prenatal care at all.

The last row illustrates numbers for pre-term births, which occur before 37 weeks of gestation. We can see again that black women are at highest risk overall, and among Hispanic subgroups, Puerto Rican women are at highest risk.

Lack of prenatal care leads to increased risk of infant mortality. Infant mortality is defined as the death of an infant in the first year of life. In 1991, a rate of 9.8 infant deaths per 1,000 live births was the lowest recorded in the United States' history, but black infants continued to have the highest infant mortality rate, and died at more than twice the rate of white infants. Those numbers were 18.6 versus 8.1 for white infants. Looking at the breakdown according to race and ethnicity, there are vast differences. The American Indian and the Alaskan Native rate was the second highest at 13.9, but this is in contrast to the infant mortality rate which was lowest among Japanese American infants. Among the ethnic subgroups of the Hispanic population, there was wide variation. The infant mortality rate was eight per 1,000 live births for Cuban-American infants and 13 per 1,000 for Puerto Rican infants.

This slide also divides the infant mortality rate into neonatal and postnatal deaths. A neonatal death occurs at less than 27 days of life. A postneonatal death occurs after 27 days of life to less than one year of life. Once again, we see that the neonatal death rate is highest for black infants and lowest among Japanese infants.

Several socioeconomic and demographic factors associated with the risk of low birth weight have been mentioned. Other factors include being 30 years of age or older having a first birth and being a teenage mother having a second or higher birth. Some of the other things we have already mentioned include low income and lower educational attainment. It is important to keep cigarette smoking in mind - and sometimes that's overlooked. Cigarette smoking is one of the strongest behavioral risk factors for low birth weight. Birth weight is the single most important predictor of infant survival, and low birth weight is defined as a weight less than

2,500 grams, or less than five pounds and eight ounces. These infants are known to be at increased risk of morbidity and mortality. Compared with infants that are of normal birth weight, low birth weight infants are five to ten times more likely to die within the first year of life. Low birth weight may result from pre-term birth or poor fetal growth during pregnancy. There is a higher incidence of low birth weight among black women, as we have seen. As seen in this slide, black infants have the highest rate. I think what is interesting about this slide is that when you look at 1970 and at 1989, you see that the percentages haven't really changed. So we do not seem to be able to combat this particular problem.

The next slide gives a breakdown in terms of race and ethnicity. In 1988, the percentage of low-birth-weight infants for black mothers was more than twice the rate for white mothers as depicted in the previous slide. Puerto Rican mothers ranked second highest and have the highest percentage among the Hispanic subgroups. Among Asian-American women, Filipino mothers have the highest percentages of low birth weight, and Chinese mothers have the lowest proportion of births that were low birth weight. The American-Indian and Alaskan Native rates were six percent. This slide also demonstrates very low birth weight percentages. Very low birth weight infants are those weighing less than 1,500 grams, or less than three pounds and four ounces. These babies are at the greatest risk of death. As you can see, black infants have the highest very low birth weight and death rate, and Puerto Rican infants are second, with Chinese infants having the lowest rate.

We know that women who have early comprehensive care generally have favorable outcomes. Those who have inadequate or no prenatal care experience complications such as low birth weight and infant mortality. It's time to determine what opportunities exist to reduce the incidence of low birth weight and its accompanying morbidity and mortality, and to find those interventions that are likely to be effective in improving the health status of women of color and their infants.

HIV/AIDS

Now I'm going to discuss HIV. Let me just start by saying that AIDS, or Acquired Immune Deficiency Syndrome, is caused by a virus referred to as the Human Immune Deficiency Virus, or HIV. HIV is known to be contracted in primarily four ways — through sexual intercourse, through shared use of contaminated needles, through infected blood supply, and through transmission from an infected mother to her infant. HIV attacks cells that are called CD4+ T-lymphocytes. These cells are attacked by the HIV virus, and this impairs the ability of the body to ward off infections. At this time, prevention is the only known means of controlling the AIDS epidemic.

This slide demonstrates that from 1984 to 1989, the annual number of AIDS cases increased dramatically among all racial and ethnic groups. We know that many women are unaware that they are at risk for HIV infection. Infected women often remain undiagnosed until the onset of AIDS. A woman may not know that her sex partner uses intravenous drugs or is bisexual or practices risky sexual behavior. In 1992, HIV was the fourth leading cause of death, following cancer, accidental injury, and heart disease, in women ages 25 to 44. In New York and New Jersey, it's the number one cause of death for women in this age group. Among adults, men with AIDS outnumber women. But although women currently represent a relatively smaller percentage of individuals with HIV, they are the most rapidly growing segment of the population of HIV-infected individuals and their numbers are increasing dramatically. This upward trend portends increases in HIV-related mortality in women.

This slide is a little bit busy, but the top of it gives a breakdown according to race and ethnicity. Along the side is the age of diagnosis, and at the bottom, the total number of women who are affected. This disease disproportionately affects women of color, and specifically, African-American and Hispanic women account for 74 percent of women diagnosed with AIDS.

This slide demonstrates that black, non-Hispanic women have the highest number of cases. American-Indian and Alaskan Native women have the lowest. This data is from 1991, so the numbers are higher now. The highest number of reported AIDS cases is diagnosed in women in the age group 30-34 years of age and this crosses all racial and ethnic groups. This means that women in this age group have probably been infected with HIV for years, and will be infected for most of their reproductive lives. The next slide basically demonstrates that in 1990, black women had the highest death rates.

In this particular slide, the first line reads "injecting drugs" and the second line reads "heterosexual contact." Across the top, you see the racial and ethnic groups. For cases diagnosed in 1989, the major categories of transmission among adolescent and adult males were: homosexual and bisexual contact at 66 percent, injecting drug use at 18 percent, or both at seven percent. However, patterns in the transmission of HIV differ for males and females, and differ among racial and ethnic groups. In 1991, except for Asian and Pacific Islander women who reported a higher heterosexual exposure, more women reported injecting drugs as the exposure category. So it's clear that injecting drug use creates an extremely high risk of exposure to HIV infection. Between 1985 and 1993, the proportion of persons with AIDS who reported heterosexual contact as a risk increased. Heterosexual transmission is the only exposure category in which females predominate. In 1993, 65 percent of the cases acquired through heterosexual intercourse were females. Consequently, heterosexual contact is becoming progressively the principal mode of HIV infection in women.

There are a few more things that I would like to tell you about HIV in women. As we have seen, it has spread through diverse segments of the population. The rate of AIDS and modes of exposure vary substantially, both among and within racial and ethnic populations. The case definition for AIDS includes invasive cervical cancer along with pulmonary tuberculosis. This means that a woman who is HIV positive may be at an increased risk for developing cervical cancer, and conversely, a woman who has cervical cancer may be at increased risk for being HIV positive. In addition, persistent cases of vaginal candidiasis or yeast infection, are more frequent among women who are HIV positive. To help increase awareness about this particular issue, in 1992, the FDA required that manufacturers of drugs or medications used to treat yeast infections include a new warning label on their product. This label generally warns women that frequent vaginal yeast infections may be the result of a serious medical condition, including HIV infection, and it advises women with these symptoms to see their doctors. Some of the preparations that must carry this warning are Monostat 7 and Gyne-lotrimin. Furthermore, in 1993, the FDA announced that contraceptives such as birth control pills and Norplant must carry labeling that states that their products are intended to prevent pregnancy but do not protect against AIDS or STDs (sexually transmitted diseases).

I want to briefly discuss women and children. The annual incidence rates of AIDS among children and among women of childbearing age have been increasing more among Black and Hispanic population groups than among other racial groups. Perinatal transmission from mother to infant accounts for most of the HIV infection among children in the United States. Approximately 100,000 women of childbearing age in the United States are infected with HIV, and an estimated 7,000 infants are born to HIV-positive mothers each year. Most babies born to HIV- infected women do not become infected, but of the approximately 7,000 infants born to these mothers each year, one to two thousand become infected. The rate of transmission from mother to infant is estimated to be between 15 to 30 percent. No one knows when transmission occurs. It may be during childbirth, or it may occur earlier in pregnancy. Also, a child can become infected after birth through breast feeding.

Data available from AIDS clinical trials have indicated that early treatment with

Zidovudine or ZDV therapy can decrease morbidity and the frequency of opportunistic infections, such as pneumocystis carinii pneumonia, in HIV-infected individuals. Another clinical study, designed to look at HIV transmission from mother to infant, was recently completed that suggested treatment with ZDV may help lower the risk of HIV transmission from mother to newborn. Pregnant HIV-infected women meeting certain criteria were given ZDV orally. Oral therapy was started between 14 to 34 weeks gestation and continued for the duration of the pregnancy. Intravenous ZDV was also given to these women during labor and delivery. Finally, ZDV was given to the newborn orally for the first six weeks of life. This clinical trial demonstrated that ZDV reduced perinatal HIV transmission to about eight percent. Compared to a 15 to 30 percent transmission rate in pregnant women who do not receive ZDV, this therapy seems very promising.

However, there are some questions and limitations. The study did not evaluate the risk or benefit of ZDV use in the first trimester because of the possibility of causing birth defects. In addition, the study has yet to provide information about the long-term side effects for infants treated with ZDV who do not become infected with HIV. Also, it's important to understand that the particular treatment substantially reduced, but did not eliminate, the risk of HIV infection among infants. In any case, this therapy is potentially life saving for those infants who are at risk for exposure to HIV during pregnancy. However, it is important to remember that many pregnant women who are HIV-infected receive no prenatal care, or inadequate prenatal care, so some challenges remain. All women of color, especially pregnant women, who are HIV-infected should be made aware of these findings, and if they are appropriate candidates, should be offered this new therapy.

Special Presentation

Special Presentation

"Women of Color and Health Care reform"

Agnes Donahue, D.D.S., M.Sc.D., M.P.H.
Office of Intergovernmental Affairs, U. S. Public Health Service

(Note: The following presentation was printed from a direct transcript of the proceedings and has not been edited by the presenter.)

This model of holding state meetings and developing state initiatives, going back to work in your states and making things happen, and then coming back together again, is a model that works for women's health. Region VIII came forward first with this model, but if you listen to what's being said about the new models of management, a lot of people are asking, "Can it work?" Those models based on empowerment, those models based on leadership where the leader is the facilitator that empowers others to make it happen, do work. And Region VIII is living proof that those models work.

Some of the things I want to talk with you about today are going to be very important. First of all, I bring you greetings on behalf of the Assistant Secretary for Health, Dr. Philip Lee; the Principal Deputy Assistant Secretary for Health, Dr. Jo Ivey Boufford; the Surgeon General, Dr. M. Joycelyn Elders; and the Office of Intergovernmental Affairs directed by Anthony Fitzpatrick. I can't tell you how happy I am to be here with you in this forum, because this conference, Women of Color Working Together, is the second in this region, and it is an example of vision put into action. The list of people who have shared that vision and made this be is very, very long, and it includes members of both the Planning Committee and the work groups for both conferences in this region — the first one, "Minority Women: Dimensions in Health", and this one.

Then there are some very special people. People like Hugh Sloan, the Regional Health Administrator for Region VIII who you met on the first day — a man who stood and said, "With this activity, I can stand aside, and the reason for that is because there is such good, strong leadership in this region for women." But I'd like to point out that when a person says that he or she can step aside (we all know because we've been in work environments, where people don't step aside, they stay to control), that is a kind of leadership that does empower. I just want to recognize that Dr. Sloan, in working with him over the years, has always been that kind of leader, and has always been supportive of women and women's health. There have been others. Dr. Audrey Nora, the former Regional Health Administrator, who came forward with the support and funds to make the first conference happen; Charlotte Gish, the family planning consultant; and Jane Wilson, who is now a public health consultant for Region VIII. All of these people, every last one, have worked. I can't tell you how much work, but all of you, since I'm sitting here looking at an audience of women, every last one of you has an idea, because we're the ones who always get the opportunity to do the impossible with very little. So you know how much these women have worked to make this happen.

HEALTH CARE REFORM

Now I've been asked to talk with you about health issues for women of color and particularly the impact of health care reform. When I was first called back in January and asked to address this topic, I had already been talking about it. I had been talking in terms of the Health Security Act all over the country, and I was expecting by this time to be able to talk with you about the implementation of that Act. But as you know, we're looking at some-

thing very, very different right now. Just the same, sometimes when seeds are sown, it's with the thought of one thing, but as it happens, it's every bit as appropriate, because something new comes about. And there is something new that we all need to be involved in, and for that reason it is very, very, timely that this was the topic chosen at that time.

These are very exciting and challenging times, because in the past two years, policy makers at the state, national and local levels, representatives from the business community, both large and small, health and other professionals, as well as private citizens, have all come together to engage in a dialogue aimed at changing our health system. While the national system debate has become markedly slowed, health system reform is moving forward and it's moving at a very rapid rate. It's moving in the states. It's moving in your states. It's happening through the many private sector reforms and through the movements toward managed care. All of this together is already changing the way health care is delivered in this country. It is critical that all women, and especially women of color, participate in this dialogue. With so much of the early reform attention focused on the personal care part of the health system, like doctor visits, hospital care, other direct services, and payment systems, health reform almost evolved into insurance reform.

Over the past two years, a lot of public attention has been focused on the health system, and we've heard a lot of discussions about what we should do about the 58 million people who are uninsured. But true health system reform has to have two components, both the personal care component and the public system component because the public system is the infrastructure that we all need to be healthy. I hope this works. Public health encompasses the infrastructure that insures quality data systems so that health trends are recognized and can be acted on to form the basis of sound policy decisions and knowledge-based delivery systems, the infrastructure necessary to prevent epidemics and the spread of disease, to promote and encourage healthy behavior, to prevent injuries, and to insure that communities are protected from environmental hazards. It's the infrastructure that attends to assurances for the safety of housing, work places, food, air, and water, and it responds to disasters and assists communities in recovery. Along with these vital functions, public health also insures such special access initiatives as the safety net programs that protect the most vulnerable in our society and the population-based health initiatives of regional and national priority, such as smoking, violence, AIDS and HIV infection.

The health care reform debate cannot be separated from attention to the larger system. That's why there is an even larger vision for the health system that is part and parcel with reinventing public health, and it has to be that. This means revitalizing public health and weaving it into a reformed personal care system, where all sectors of the health system, public health and personal care, are working together to protect and improve the health of the nation's people. Because it's this kind of integrated superstructure, with attention to both public health and personal care that's important for all, and particularly for women and families in communities of color.

STATE REFORM

I mentioned earlier that health system reform is happening in the states, and I want to talk just a little bit about that. This year, there are some profound changes that are taking place through marketplace forces, in state legislatures, through state legislation and through the regulatory process. Increased utilization of Medicaid waivers like the 1915B and the 1115 waivers is an example of where the regulatory process is the key change instrument in health reform. Some of you may be involved with the development of these waivers in your states. In brief, the 1115 and 1915B waivers allow selective legislative and regulatory requirements of the Social Security Act to be waived.

These waivers usually affect Medicaid and

Aid to Families with Dependent Children programs(AFDC). The 1915B waivers apply only to the Medicaid program — they're very narrow authorities for limited waivers, such as certain requirements for provider choice or comparability of services across populations in the state. The 1115 waiver, however, is much broader. It's a broader authority for demonstrations and experiments. This particular kind of waiver allows states greater flexibility to test new ways to improve Medicaid and AFDC programs. This type of waiver can dramatically change Medicaid, and many states are expressing interest in the 1115 waiver.

It seems the trend is clearly in that direction, and the Secretary of Health and Human Services has recently announced in the Federal Register policies and procedures that will guide the Department in reviewing these state proposals for 1115 waiver demonstrations. That same Federal Register notice also calls for states to obtain public comment before they submit proposals to the Federal government. This is a new and very important approach. The Department wants to be sure that people who may be affected by the demonstration projects, and also those who are concerned, have an opportunity to participate in the decision-making process. States will now offer the opportunity for the public to express their positions, and I urge all of you to take advantage of this opportunity. Work with your organizations and share the information with others so that they can also participate. You and you alone can speak to the needs of communities that you know and the communities that you serve. I believe that someone said yesterday that there are many, many ways to have a voice. There are many ways to be heard. There are many ways to get involved in the decision-making process. This process is going to be one. We've got to make sure that we are at the table and that we do have an opportunity to participate in decisions, and this is an opportunity to do that. We do have copies of that Federal Register notice for you, and they are available for you here today.

The issues that encompass personal health and public health are particularly important to women and families in communities of color, because women's health is influenced by many parameters — economic, environmental, physical, psycho social, behavioral, and political. Sometimes when we talk about health, we get so locked on the physical manifestations, the diseases, that we see when health is so seriously compromised, that it's breaking down. But I want to start off by talking about some of the other factors first — factors like income and other social determinants.

ECONOMIC AND SOCIAL DETERMINANTS OF HEALTH

Poverty

The median income for families in communities of color is a full one-third lower than that of the overall median income, and when we start to look at the economic status of women of color, we get an even more grim picture. Data from the census department, for example, show that African-American women as one group is the poorest group of women that we have data on. Thirty-seven percent of African-American women in this country live in poverty. Hispanic women are not far behind at 32 percent. Information is very important. It's important that we share that information, because when we share information it imparts knowledge. Knowledge breaks down barriers, and it eliminates destructive myths. Myths can hide reality and lower sensitivity to real problems and real issues. One such myth is the myth of the model minority. This label has helped to desensitize to the diversity of those that we have so casually lumped under a nomenclature, Asian/Pacific Islander. When we look beyond the simplicities of a euphemism, there are the realities of people, of communities, of families, of women. According to the Bureau of Census, about 14 percent of Asian/Pacific Islanders live in poverty. That's from the 1990 census, as you look at the broad complexities of the numerous ethnic groups that are lumped as Asian/Pacific Islanders.

When we consider the startling information that Mary Chung and others have shared

with us in the past two days, we know that those numbers don't even begin to tell the story. No matter what the racial group, the environment of poverty takes its toll. We see the effects and the grim statistics on our streets. We see it in the struggles of families and individuals in a society where basic needs are becoming more costly and the resources to afford them more scarce. Yes, these are exciting times, but they are also times of great tragedy, particularly for the most vulnerable in our nation, the disadvantaged, the disenfranchised, the women and children in communities of color.

The Declining Family
There are the tragedies of the declining family. This has taken a major toll on communities of color. In the past ten years the number of children living in one-parent households has more than doubled, and most are headed by single women. Up to 88 percent of children living in single parent households are Black or Hispanic, and more than 65 percent live below the poverty line. We talk a lot about the number of children who live in poverty and the impact on their lives. It's important that we do this because children are our future. We can never forget that children live in poverty because their families live in poverty, because their mothers live in poverty.

HEALTH ISSUES FOR WOMEN OF COLOR

The Epidemic of Violence
We have the tragedy of violence in our streets and in our homes. We're living in an epidemic of violence. Abby and others have described the tragic picture of violence against women, women of color. I want to say just a few more words about domestic violence. More than 30 percent of all emergency room visits by women result from domestic violence. Every year, more than 2.7 million cases of child abuse and neglect are reported — are reported! These are just the ones that are reported! Yet, we know that violence leads to more violence, and it's a vicious cycle. We've got data showing that women who are physically abused by their partners are more than twice as likely to abuse their children. Children who see violence and experience violence in their homes are more likely to physically injure themselves or others later in life. Of course, we have the tragedies inherent in the physical discrepancies between the various populations in this country — the women and children in families in communities of color. Communities of color take the lion's share of this burden. The people in this room know about these disparities very, very well, because we see them on T.V. We hear about them. We work with them every day, and some of us have been there.

You know all too well that there are far too many haves and have nots, and that influences health. The disparities have a lot to do with income, with emotional levels, with working and living environments, with life stressors. Too many women in communities of color — African-American, Hispanic, American Indian, persons of Asian and Pacific Island decent — too many fall on the wrong side of the line of plenty, because disproportionate numbers are often on the short side of factors like the health disparities that show up worse when we make racial comparisons.

Infant Mortality and Low Birth Weight
Disparities like high rates of infant mortality and low birth weight. Our nation has a scandalous track record of disparities for infant mortality, low birth weight, and poor pregnancy outcomes for African American, Puerto Rican, and other women of disadvantaged backgrounds. The rate of low birth weight for babies born to African-American women is almost twice that of White women, and we haven't made a dent in that gap in 30 years — 30 years! In some communities of color, two — almost three — times as many babies die before their first birthday, as those born to White mothers. We know that early prenatal care reduces the number of infant deaths, and we've made some improvements. But still, less than two-thirds of American Indian, Mexican-American, Puerto Rican, and African-American women get first trimester care. This is an appalling statistic for an

industrialized country! If we compare our numbers to women in other industrialized countries (like Japan, Sweden, or Canada, where 95 to 98 percent of women get prenatal care in the first trimester of pregnancy), we don't look so good. We've got to make sure that all women who need early prenatal care get it so that we can stand shoulder-to-shoulder with any industrialized nation in the world. If it's a worthy goal to compete in the computer chip market, it's worthy that we compete for our children.

Chronic Diseases

Then we have the disparities of the chronic diseases, like heart disease, diabetes, hypertension, stroke. Heart disease kills seven times more women every year than breast cancer. In communities of color, heart disease, hypertension, stroke, diabetes, they all take a very, very serious toll. The rates of diabetes are three times higher among American Indian women in the southwest, and higher among African-American women and Asian women.

Yet many of the diseases and conditions that affect women and lower the quality of their lives are preventable. We can eliminate one-third to one-half of the disabilities that women have by practicing good preventive care — by changing risk reducing behaviors and with good preventive practices. Factors such as not enough exercise, unsafe sexual practices, use of alcohol, use of tobacco, use of other drugs, late or no prenatal care, lack of screening for conditions like breast and cervical cancer. Prevention can greatly reduce the rate of illnesses for these diseases and conditions that affect women and cause frailty and lower quality of life. But we've not been as successful in getting the prevention messages out there to women, and particularly to women of color, old women, women in isolated settings, such as cities and rural areas, and women whose primary language is not English. This is a serious problem, because it's knowledge and education that are the tools that women need to be full partners in proving their health.

Cancer

There are disparities in the death rate from breast and cervical cancers. I want to talk just a little bit about that. We all know the numbers. We've heard them over and over again. One in nine women will develop breast cancer and breast disease — we could almost take a litany in this group. But what does that mean? It means that right now, 2.6 million American women have breast cancer. It means that 183,000 thousand new cases will be diagnosed each year, we know that. We've heard this. But a part that we don't hear as often is that some groups of women of color have higher death rates from breast cancer, even though they're less likely to develop the disease. The fact is that Native Hawaiian women have the highest rate of death from breast cancer. Access is a key factor. We have no way, right now, to prevent breast cancer, but we know that early detection can reduce the number of deaths from breast cancer by 30 percent. Yet 64 percent of women 50 years or older have never had a mammogram, and the percentages are even worse for American Indian women, for Asian and Pacific Island women, for Hispanic women. They're less for women with less education, and for women whose income is less than $10 thousand. You heard Sylvia's presentation when she said that she has to depend on charitable contributions to get mammography services for the women she serves.

What about cervical cancer? When cervical cancer is found and treated in its earliest stages, it's almost 100 percent curable. Yet data show that women, and particularly disadvantaged women, are not receiving Pap tests. Cervical cancer is one women's health issue where we really need a paradigm shift. We need this because there's a serious problem. Women are suffering in silence with this disease because for too long, we have allowed the myth that a risk factor is a label. Women are suffering and sometimes dying without the support that they need with this disease. We don't see the camaraderie of support for cervical cancer survivors. We don't see brightly colored ribbons for women with cervical cancer. We don't hear demands for actions against cervical cancer. Women of color are disproportionately affected by cervical cancer. A study in Los Angeles showed that cervical cancer rates among

Latino women were 250 percent higher than those of non-Hispanic White women. And rates for Black women were 50 percent higher. Mary Chung told us about the seriously high death rates for cervical cancer among Chinese women. Our challenges for cervical cancer, our challenges for cancer among women, go well beyond the gender-specific and gender-predominant malignancies.

Lung cancer is now the leading cause of death among women. It surpassed breast cancer back in 1986 and continues to rise at a rate unit of one rate unit per year. Lung cancer deaths among women have increased by 400 percent in the last 30 years, largely due to increases in smoking. We had some great successes in reducing the number of people who smoke in this country, but we haven't been nearly as effective with smoking cessation initiatives for women. More women begin to smoke every day, and of the ones who are already smoking, not nearly as many have quit. Smoking's a particular problem for adolescent women. It's estimated that 3,000 women become new smokers every day, and many of them are teenage girls. We have data from the Centers for Disease Control that show that girls outnumber boys among those who smoke. This slide, as you can see, shows the data from 1975 to 1987, but the recent Surgeon General's report points out that this trend has not changed in 19 years.

Substance Abuse and Mental Health
We've heard some excellent presentations about the problems faced by women of color with regard to alcohol, substance abuse, and mental health issues. You've heard about them from women who are working in their communities, who have models that work and who are making those models work. The problem on the national level is far from solved, and the issue of services is barely touched. But I'd like to acknowledge a person who's with you here today, and that's Pam McDonald from the Office of Women's Health Services in SAMHSA, the Substance Abuse and Mental Health Resources Administration. That agency, together with the Indian Health Service, are two agencies in the Public Health Service that are charged with addressing this whole issue of services around substances, alcohol and mental health for women. Pam is new to this arena, and I hope that you will add her to the network, because we've got a lot of work to get done in this area.

AIDS and HIV Infection
I want to close with just a few words about AIDS and HIV infection. You've heard already that women are the fastest growing group of persons with AIDS. We've heard that over and over again. We all know that Latino women and African-American women and their children are disproportionately affected by this disease. Estella Parrott mentioned yesterday, but it bares reinforcing, and that is that heterosexual transmission for women is a real concern. The Centers for Disease Control reported this past summer that for the very first time in the history of the HIV epidemic, more women in the United States were infected with the HIV virus through heterosexual transmission than through injecting drug use. I wanted to point that out because this issue comes across, but it often doesn't come across as strong as it needs to. It's strongly linked as well with substance abuse, and often in our poor communities and in our poor communities of color, we see high instances of substance abuse. Women and their partners in these communities are at risk. Women are at risk. There are implications for adolescents because we have no way of knowing what the practices of our partners are, and we need to know our risk. We need to know the practices of our partners, and we need to know how to protect ourselves against this virus.

FACING THE CHALLENGES

These are some of the challenges that we face as individuals, as women and as families in communities of color. There are issues that underscore our experiences, and our experiences and issues must be factored into policies that affect us. But what do we do, and where do we go from here? Well, we start with forums like this. We start by bringing ourselves together to share information, to

share experiences. We sponsor activities that seek the opportunity to promote public education and community mobilization, so that women not only know their risks, but also know what to do about them. We identify and use every opportunity to empower communities and women to participate fully in every dialogue, including the dialogue on health reform - to participate in every dialogue that promotes better health for ourselves and for our communities.

But as I look out over this audience, I know that this is an audience who knows that. You know what to do because you are doing it, and you've been doing it for years. So in this audience I can just say, "Keep on." Keep putting the messages out there. Use every opportunity to empower women to take charge of their health. Keep working to build the kinds of linkages between federal, state, and local agencies that influence all of the health determinants in our communities. Build the linkages between corporate and private players. Continue to weave the networks in our communities, in our churches, our schools, and most of all, the networks between individuals, because we've all got a share in this. And by all means, continue to work to ensure that all branches of government — federal, tribal, state, local, executive, legislative, and judicial — every last one of them — remains accountable. The challenge is indeed before us, and the challenge is to bridge those gaps on all the determinants of health — economic, physical, social, spiritual, environmental, and political. When we do this, we will have health that is both the absence of disease, and the presence of well-being.

Conference Workshops Summary

Conference Workshops Summary

Nine workshops in three tracks were presented during the conference. The tracks and the workshop topics represented the ideas of the Planning Committee and reflect many of the issues they wished to address.

TRACK I - PRESCRIPTION FOR A HEALTHY COMMUNITY

This track was designed to focus on strategies for improving the health and wellness of the community. Included were examples of actual community programs which work, organizing the community, advocacy and building upon community and cultural traditions in order to strengthen the family.

Workshop A - Community Wellness Strategies
This workshop focused on developing a wellness "battle plan" in order to heal the community and keep it well. Presenters shared ideas for unique community health programs benefiting women of color. Ms. Ahn discussed activities she has conducted in the Asian/Pacific Island community and Dr. Richardson presented community projects her clinic has sponsored in the African American community.

Presenters: Jae Wha Ahn, M.S.W., Director, Division of Community Education
Asian Pacific Development Center, Denver, Colorado

Terri Richardson, M.D., Medical Director, Eastside Neighborhood Health Center
Denver, Department of Health and Hospitals, Denver, Colorado

Moderator: Kaetz Beartusk, Wyoming Department of Family Services

Workshop D - Prescription for a Healthy Community
The presenters gave proven examples of how to organize the community and establish linkages with key community agencies in order to target services to people of color and to advocate for the health issues of women of color. Ms. Adams has advocated for all ethnic communities in Salt Lake City, and Ms. Jarmillo discussed how she developed a community profile in order to determine special health needs in her community.

Presenters: Sandra Adams, Ethnic Health Specialist
Utah Issues, Salt Lake City, Utah

Selina Jaramillo, Senior Care Coordinator
St. Mary-Corwin Hospital, Pueblo, Colorado

Moderator: Mary Lou DeZeeuw-Ramirez, U.S. Public Health Service, Region VIII

Workshop G - Healthy Communities = Healthy Families
The workshop looked at the close relationships of culture, community and family. Ms. Russell discussed how the values of the culture and community can be nurtured in order to produce healthy families and individuals.

Presenter: The Honorable Angela Russell (Crow), State Representative
Psychotherapist in Private Practice and Consulting, Lodge Grass, Montana

Moderator: Joyce DeVaney, U.S. Public Health Service, Region VIII

TRACK II - CARING FOR THE CAREGIVERS

In order to provide services to others, the caregiver needs to attend to herself. This track featured methods for dealing with anger, for becoming more assertive and for taking responsibility for making positive and healthy choices. Ms. Bear Don't Walk has done extensive work in the area of overcoming anger.

Workshop B - The New You Moves Forward!

Becoming whole and empowering yourself by overcoming the pain, anger and trauma which can affect your health.

Presenter: Marjorie Bear Don't Walk (Salish), Executive Director
Indian Health Board of Billings, Billings, Montana

Moderator: Deborah Henderson, Montana Department of Health and Environmental Sciences

Workshop E - Making Positive Choices

The presenters offered ideas for how to take individual responsibility for making lifestyle choices which improve the health and quality of your lives. Ms. Pegues presented on the role nutrition plays in keeping us healthy, and Ms. Takeda discussed the importance of physical fitness.

Presenters: Jo Ann Pegues, R.D., Aging Program Specialist
U.S. Administration on Aging, Region VIII, Denver, Colorado

Tomiko Takeda, M.Ed., Wellness Consultant
Littleton, Colorado

Moderator: Barbara Grant, U.S. Public Health Service, Region VIII

Workshop H - Asserting Yourself Positively

Utilizing helpful tips and proven techniques, the presenters demonstrated how to be assertive in a positive manner in order to fulfill your needs and be healthy. Both Ms. English and Dr. Gomez discussed how these techniques can improve your mental and physical well-being.

Presenters: Demetra English, M.P.H., Policy Analyst
Colorado Department of Health Care Policy and Financing, Denver, Colorado

Adelina M. Gomez, Ph.D., Professor of Communication Studies
University of Colorado at Colorado Springs
Colorado Springs, Colorado

Moderator: Monyett Ellington, Colorado Department of Public Health and Environment

TRACK III - OVERCOMING BARRIERS TO CHANGE

Despite barriers faced by women of color in seeking health care services, there are ways of overcoming these barriers, including ensuring that communities have providers who are sensitive to their needs and able to provide services which are culturally competent. The track also includes an examination of alternative healing therapies.

Workshop C - Recruiting and Retaining Providers of Color

The presentations provided both the government perspective by Ms. Jackson and the community perspective by Ms. Yardley for assuring an adequate supply of culturally competent providers in order to meet the future needs of our communities.

Presenters: Marva Jackson, Regional Program Consultant, National Health Service Corps
U.S. Public Health Service, Region VIII, Denver, Colorado

Linda Yardley (Taos Pueblo), Student Services Specialist, Center for Multicultural Enrichment, University of Colorado Health Sciences Center, Denver, Colorado

Moderator: Betty Roybal, U.S. Public Health Service, Region VIII

Workshop F - Adding Warmth and Compassion to our Health Care Services

How to satisfy the "customer" was the focus of this workshop. Ms. Beartusk, who has knowledge of all cultures and Dr. Orme who works with refugee populations discussed how to assure that services and programs that serve women of color are sensitive to their needs and provided in a culturally competent manner.

Presenters: Kaetz Beartusk, M.P.H., CAS III, Medicaid Consultant
Wyoming Department of Family Services, Cheyenne, Wyoming

Lillian Tom-Orme, Ph.D. (Navajo), Program Director
TB and Refugee Health Program, Utah Department of Health
Salt Lake City, Utah

Moderator: Lydia Cole, U.S. Food and Drug Administration, Denver, Colorado

Workshop I - Blending Alternative Therapies and Spirituality with Western Medicine

An examination of traditional healing methods used by the various cultures and the connection between spirituality and health and survival. Ms. St. Clair provided a description of an Indian healing room at the hospital in Lander, and Ms. Valsquez talked of the need to consider cultural beliefs when caring for clients of culture.

Presenters: Sandra St. Clair (Pawnee), Community Relations Specialist
Lander Valley Medical Center, Lander, Wyoming

Diana Velasquez, Curandera (Folk Healer), Program Manager
Mental Health Corporation of Denver, Denver, Colorado

Moderator: Geraldine Madrid, Latin American Research and Service Agency (LARASA)
Denver, Colorado

Appendix

Appendix

- Ethnic Women of Excellence in Health Awards
- Facilitators for Networking Tables
- Summary of Ethnic Events
- Listing of Participants
- Region VIII State Meetings

Ethnic Women of Excellence in Health Awards

We congratulate the four women of color below who were designated by their peers as exemplifying excellence in service to their communities, concern for those in need, leadership and high professional standards.

Asian/Pacific Islander Woman of Excellence in Health

Sumiko Tanaka Hennessy, Ph.D.
Executive Director
Asian Pacific Development Center
Denver, Colorado

Hispanic/Latina Woman of Excellence in Health

Silvia Guillermina Corral, M.D., M.P.H.
Medical Director, Wasatch Homeless Health Project
Salt Lake Community Health Centers
Salt Lake City, Utah

African American Woman of Excellence in Health

Ruth L. Fuller, M.D., F.A.P.A.
Associate Professor of Psychiatry
University of Colorado Health Sciences Center
Denver, Colorado

American Indian Woman of Excellence in Health

Bertha Gipp, R.N.
Project Coordinator, Maternal and Child Health
North Dakota State Department of Health and Consolidated Laboratories
Bismarck, North Dakota

Facilitators Networking Tables

Silvia Corral, M.D.	Cancer and Diabetes
Jane Wilson	AIDS and Sexually Transmitted Diseases
Ruth Fuller, M.D.	Mental Health
Geri Reyna-Challis	Substance Abuse
Joyce DeVaney	Teen Pregnancy
Abby Trujillo Maestes	Domestic Violence
Charlotte Gish	Menopause
Georgia Pappas	Language Barriers
Mary Lou DeZeeuw-Ramirez	Physical Activity
Jo Ann Pegues	Nutrition
Estella Parrott, M.D.	Contraceptives
Nancy Thomann	Aging Issues
Cecelia Fire Thunder	Stress Reduction

Special Family Planning Session
"Minority Client Preferences for Family Planning Services"

Vivian Lee, Consultant
Office of Population Affairs
Seattle, Washington

Ethnic Events

The following ethnic events were held during the conference and served to foster awareness for participants of the some of the differing traditions and values of our four cultures.

" Que Pasa?" (Spanish for "What is Happening?")

This event featured storytelling by Geraldina Lawson, R.N., Administrator of the Globeville Community Health Clinic in Denver. She related a story in both English and Spanish which highlighted several Hispanic beliefs and traditions.

Event organizers were Selina Jaramillo and Betty Roybal.

"Balancing the Yin and Yang in Your Life"

The Thursday afternoon break was used to demonstrate some of the principles of Tai Chi by Toni Iadresin, D.C. and to provide a relaxation exercise by Tomiko Takeda, M.Ed., a Wellness Consultant. Jae Wha Ahn served as facilitator. The event highlighted the Asian value of balance in our everyday lives.

Event organizers were Jean Kajikawa and Tomiko Takeda.

"Indian Honoring Ceremony"

The traditional Indian honoring ceremony was used to honor the four ethnic women who received awards for their excellence in the field of health. The idea of honoring these women was suggested by the American Indian members of the Planning Committee.

Event organizers were Cecelia Fire Thunder and Jane Wilson.

"Umojo (Unity) Ceremony"

The closing ceremony was planned around the principle of "Umojo" from the African American Kwanzaa ritual which is increasingly being celebrated by African-American families.

Event organizers were Kathy Rollins of the National Conference of State Legislatures and Nancy Thomann.

Region VIII State Meetings

The six states in Region VIII held two meetings during the course of the conference. States were asked to review their progress and activities related to the health of women of color since the 1993 conference and to consider recommendations for future activities.

COLORADO - Chair, Monyett Ellington

Participants in the Colorado meetings developed a number of suggestions for future women of color conferences. Additionally, the group presented the following recommendations for consideration by the U.S. Public Health Service, Office of Population Affairs, Office on Women's Health and Office of Minority Health:

I. Investigate and implement insurance coverage for alternative health care procedures.

II. Fund and insure the implementation of functional outreach to involve and serve minority communities and target populations, such as mobile health-care service vans.

III. Disseminate information about successful research studies.

IV. Additional definitions of "community", other than geographic boundaries, should be utilized.

V. Create and/or fund awareness programs.

VI. Educate consumers on methods that will avoid the high fat and or salt content of many commodity items in order to counteract the nutritional limitations of the use of commodities.

VII. Minimize the fragmentation of services by promotion holistic health care and services.

VIII. Support the expanded role and numbers of women of color in health departments, administration and research.

IX. Provide emergency medical care to communities where no public transportation or communication means, such as telephones, exist.

X. Extend technical assistance necessary to assure the ability compete for grants. Small, but effective programs often lack the resources to devote to grant-writing.

XI. Require people of color representation on all grant review boards.

MONTANA, NORTH DAKOTA AND SOUTH DAKOTA - Chair, Deborah Henderson

The participants representing Montana, North Dakota and South Dakota met together and shared information and generated ideas. The following action plan was developed:

GOAL: Private, tribal, state and federal agencies will meet together to exchange ideas and information regarding resources and materials (e.g. curriculums, parenting programs, cultural awareness) related to family/maternal child health care.

Recommendation I: A statewide meeting (or tri-state to include the three states) or conference should be held to discuss who is doing what for family/maternal child health. This meeting should include, but is not limited to, the following agencies:

- Center for Disease Control
- Legislators
- Family planning programs
- Social services agencies
- Public health programs
- Appropraite state agencies
- Bureau of Indian Affairs (appropriate agencies)
- Indian Health Service
- Tribes (appropriate agencies)
- Urban Indian health agencies
- Head Start

Recommendation II: Support a tribal "Office of Women's Health".

Recommendation III: A paid position for a women's health coordinator should be established for women of color at the State Health Department.

Priorities:

1. Children's health programs in the schools, e.g. positive choices for K-12. Use available materials from:

   a. The American Heart Association
   b. The American Lung Association

2. Violence in communities:

   a. Anger
   b. Healing
   c. Parenting

3. Teenage pregnancy.

4. Substance abuse programs appropriate for women and children.

5. Keep legislators informed - lobby and advocate for women's and children's programs.

WYOMING: - Chair, Julie Lehman

Representatives from Wyoming, after reviewing a number of situations pending in the state, developed the following action plan:

I. Contact the director of the Wyoming Department of Health and request state commitment for one assigned individual within the state system to coordinate minority women's issues/health conference.

II. Mail, or make available, the recommendations and results of the Wyoming Minority Women's Health Forum held September of 1993 in Riverton.

III. Mail, or make available, copies of this session's results and activities to participants in the Wyoming Minority Women's Health Forum held in 1993.

IV. Hold a session similar to the 1993 session in 1995.

V. Submit a Wyoming mailing list to the federal and state governments.

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